‘Resisting Reproduction: An Anthropological Analysis of Unsafe Abortion in a Rural Ghanaian Village’

Nicole Webster
Department of Anthropology
Supervisors: Ass. Prof Patrick McAllister & Dr. Anne Scott
School of Social and Political Sciences
University of Canterbury
New Zealand

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Abstract

Unsafe abortion claims the lives of thousands of women every year. Globally, it is the women in Sub-Saharan Africa who face the highest risk of death and injury from abortion-related complications (Ahman & Shah 2011, p.123). Current global and national efforts to reduce incidences of unsafe abortion are ineffective in the rural Ghanaian community where this research was undertaken. This anthropological examination of key aspects of contemporary local social practice and the norms and customs which underpin it, demonstrates the necessity for many local women to utilise a dangerous plant to facilitate potentially fatal self-induced abortions as their primary means of resisting culturally-defined fertility patterns. This thesis is broadly structured around anthropologists' Scheper-Hughes' and Lock's (1987, p.6) concept of three intersectional bodily perspectives: the phenomenological individual body-self, the social body and the body as an artefact of political control. The reader is offered insight from each of these perspectives into the social practice of unsafe abortion in the lives of some rural Ghanaian women. I argue that unsafe abortion can be seen as a kind of social struggle against the local economic mode of production. The thesis provides an analysis of the position of many women within local relations of production from a neo-Marxist perspective which has been modified by concepts of class and exploitation particular to pre-industrialist societies. The modifications are taken from the theoretical positions of French anthropologists Terray (1975), Meillassoux (1972) and P.P Rey (1975). In addition, following the work of critical medical anthropologist Scheper-Hughes (1993), the thesis demonstrates the ways in which medical discourses and policy output about family planning and reproductive health which are produced and reproduced at the level of the national body politic, obscure more deeply embedded powerful ideologies and social praxis about female sexuality and reproduction which is produced and reproduced at the level of the social body within the context of popular interpretations of tradition and customary law. Ultimately, I argue that current Programmes of Action aimed at reducing incidences of unsafe abortion fail to address patterns of gender violence and patriarchal control by medicalising some village women's social suffering.

Acknowledgements

There were so many people who, in varying ways, contributed to this thesis and I wish to offer them all my sincere thanks. In particular however, I would like to thank the directors of the Non-Governmental Organisation (NGO) who allowed me access to the community medical clinic in Ghana where my fieldwork was undertaken. The nature of an anthropological investigation into circumstances surrounding unsafe abortion means that the utmost confidentiality must be maintained. I am therefore unable to reveal the real name of the NGO or its directors. I refer to it instead by the pseudonym 'Ghana KINDNESS' throughout the thesis. I chose this name because I believe it reflects the spirit in which the NGO and its members undertake their work. I am truly inspired by the integrity and commitment which these individuals demonstrate. I am certain that these qualities are why the local people speak so highly of them and their organisation despite the challenges encountered in their efforts to improve the lives of those living in the rural communities.

To the Ewe director of the village community medical clinic *akpe ka ka ka Ghanaian tatanye* (thank you very much Ghanaian father). Despite your multiple responsibilities to the clinic and other local projects, you always made sure I had the social and material resources I needed to complete my work. You displayed patience and generosity when answering my endless questions about the Ewe or about village life and I very much miss your sense of humour. Moreover, you always did your best to ensure my safety at all times; this is no small achievement when faced with my unruly love of adventure.

During the course of my fieldwork there were many people who spent time working at the community clinic as international volunteers or local healthcare trainees. In particular, I would like to acknowledge Maria (again a pseudonym), an international volunteer, qualified midwife and sexuality and rape counsellor who attended my interviews with the local women. I would also like to thank the local healthcare trainees who assisted me with triangulating data when I was trying to form an opinion about local life with some degree of accuracy. My gratitude extends again to these same people who took me to meet those with knowledge of local history or tradition and were translating informal conversations between myself and village locals on a daily basis. Of course, any flaws in the interpretation of traditions or ideas about Ewe culture in this thesis are my own. In particular, *akpe ka ka ka* Stacey (pseudonym), the trainee who provided my first significant insight into unsafe abortion in the local area and stimulated my desire to understand as much as I could about the social circumstances which surround the performance of unsafe abortion in the village.

I surely owe a debt of gratitude to the women who provided the key ethnographic data for this research by sharing intimate details about their lives and experiences of unsafe abortion. I would like to say *akpe ka ka ka* (thank you very much) and may God bless you. Performing an abortion is forbidden in Ewe culture and these women showed great courage and determination in explaining both the methods and their reasons for the practice of self-induced abortion. Thank you for your trust in me. In addition, I would like to express my gratitude to those elder local people who provided me with knowledge of local history and

customs. While I was told that books about such material existed, they seemed to be in personal possession rather than in public libraries and so I am grateful for the personal narrations I received about local Ewe life.

My fieldwork experience in rural Ghana was without a doubt one of the very best experiences of my life, yet it was also one of the most challenging. Being in a social and physical environment so foreign means that one requires assistance with many aspects of ordinary life which would normally be taken for granted. I want to offer my sincere gratitude to the people with whom I shared daily life at the clinic and to the local villagers, many of whom contributed to my experience of life in rural Ghana; you are all forever in my heart. While differences abounded, the experience of shared humanity was also a fundamental part of my fieldwork in rural Ghana. I therefore wish to thank everyone for all the laughter, mutual frustrations, trust and honesty – even when that sometimes meant I was declined access to things or people.

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Chapter One
Introduction

The purpose of this research is to examine the social practice of self-induced abortion in rural Ghana, West Africa. I began writing this thesis with the intention of providing the reader with an ethnographic experience of the village in which the research was undertaken, its ethnic Ewe people, and life in Ghana in all its vibrancy, beauty, complexity, hardship and uniqueness. There is so much to love about Ghana. However, I soon discovered that it would be impossible to describe the fieldwork experience in this way. I was faced with the great ethnographic dilemma that one cannot 'capture' life at large and place it on a page, complete. In particular, because of the nature of the subject material of this thesis, I have by necessity presented quite raw and confronting aspects of village life. I do not wish the reader to imagine that village life, and for that matter the lives of the local women, consist only of these problems; nor that the issues discussed are simply another example of 'what is wrong with Africa' (Tsey 2011, p.2). Life in the west also has its raw and confronting issues and social problems. Humanity is nothing if not a vast spectrum of social experiences shared in varying degrees and forms by all nations.

That being said, the aim of this research is an analysis of the specific social forms and reasons for the social practice of self-induced abortion in the rural Ghanaian village I have called Abladzo. Medical assistance provided by Ghana KINDNESS NGO forms part of the story of unsafe abortion in the village. The NGO established and runs the community medical clinic in partnership with the local people. One of the goals of the NGO is to empower the local villagers through the medical clinic development project. While I was in Ghana, I could certainly see how the clinic was assisting local people greatly with regard to protecting them from malaria and treating wounds and infections caused by farming injuries or accidents, and by training local healthcare workers for example. I could not however, reconcile the idea of 'empowerment' with the frequency with which local women performed unsafe abortions and subsequently required life-saving anti-haemorrhage injections from the clinic. My research was therefore led by two key questions. Firstly, *why do some women of Abladzo village*

perform self-induced abortion? And secondly, *is the NGO really helping to empower these women?*

The subject matter discussed in this thesis is of great relevance to anthropology for a number of reasons. To the best of my knowledge, much of the ethnographic data gained in this research makes an original contribution to the current anthropological literature about the Ewe tribe in the study, at least in the English-speaking world. The ethnographic data about the practice of unsafe abortion presents the idea that often coercive or indeed involuntary sexual relations are an underlying cause for the local women to perform an unsafe abortion. Sexual coercion is a newer area for research in developing countries and there are only a limited number of studies based on representative data (Erulkar 2004, p.183). The idea of 'intimate partner violence' has been linked to unintended pregnancy in some global studies (Stephenson et al 2006, Silverman, J.G et al 2007, Pallitto & O'Campo 2004, Erulkar 2004 & Gomez & Speizer 2010). However, there are very few studies undertaken in Ghana which associate sexual coercion and involuntary sexual relations with unsafe abortion (Glover et al 2003 & Bleek et al 1986).

Erulkar (2004, p.182) states that sexual coercion refers to a range of experiences which compel a person to have sex against their will. These could include 'violence, threats, verbal or physical insistence, cultural expectations or economic circumstances' (Erulkar 2004, p.182). Erulkar (2004, p.182) states also that the result of these experiences is a lack of choice to 'pursue other options without severe social or physical circumstances'. This thesis is an anthropological analysis of unsafe abortion, thus it concerns the social beliefs, kinship forms, cultural expectations and economic circumstances, which are interwoven with the social practice of self-induced abortion in the village community. I will demonstrate the way in which local women of various ages and marital status experience a lack of choice about sexual experiences or, in a broader sense, what they describe as a 'lack of control over their bodies'. These women believe that the best way they can exercise agency and assert some control over their social circumstances is to perform a self-induced abortion using a very dangerous local plant.

Much of the current biomedical literature on unsafe abortion places the problem largely within the conceptual framework of 'an unmet need for contraceptives' or a call to improvements in legal or technical service provision for abortion. This is true of the literature about Ghana also (Johnson & Madise 2009 & 2011, Geelhoed et al 2002, Hill et al 2009, Lithur 2004). Thus, the general advocated solutions to unsafe abortion are the intensification of family planning methods, contraceptive education and medical service provision at local hospitals and clinics. While it is of course true that the effective use of contraceptive methods will prevent unwanted pregnancy, it is my intention that this thesis demonstrate why it is grossly reductive to frame the problem of unsafe abortion as predominantly an issue of contraception or abortion clinic provision. Furthermore, I wish to demonstrate why contraception is currently mostly ineffective in rural Abladzo and likely to continue to be so. My argument against privileging biomedical solutions or what I refer to as medical and technical solutions, over social ones is a recurring theme throughout this study; I believe this is for very good reason.

Unsafe abortion has largely been recognised as a crisis issue since the 1990s and the significant extent to which it contributes to global maternal morbidity and mortality has become widely acknowledged (Sai 2004). Women who attempt an unsafe abortion and do not die, often still incur very severe health consequences including: sepsis, haemorrhage, uterine perforation and cervical trauma, which often lead to permanent physical impairment, chronic morbidity, infertility and psychological damage (Coeytaux 1990, McLaurin et al 1991). The risk of death from unsafe abortion is highest in Sub-Saharan Africa (Ahman & Shah 2011, p.123). Despite legal reform and global public health efforts creating a decline of one third in the global number of unsafe abortion-related maternal deaths, the WHO reports the trends in the unsafe-abortion mortality rate in Africa as an annual change or reduction rate of just 1% (Ahman & Shah 2011, p.123). Of particular concern is the fact that the actual decline occurred only between 2003 and 2008 (Ahman & Shah 2011, p.123). Despite a reduction in maternal mortality being among the eight goals of the United Nations Millennium Declaration of 2000 in its 'Health for All' programme, only one country in Sub-Saharan Africa will meet the goal by 2015 (Doskoch 2011, p.217).[1] Most sub-

[1] The country is Madagascar.

Saharan nations are not expected to meet the maternal health targets before 2040 (Doskoch 2011, p.217). It is therefore acceptable to argue that current global public health policies and programmes are not successful in achieving positive health outcomes for Sub-Saharan African women. The statistical picture painted above applies also to the Sub-Saharan nation of Ghana. Both the global reality of unsafe abortion and more specific data relating to Ghana are discussed more fully in the following chapter entitled 'Setting the Context'.

The chapter also discusses the global political environment within which the current policies and programmes of action concerning unsafe abortion are formulated. A very significant change occurred in policy direction with the formulation of the Millennium Development Goals. Previous political acknowledgement of unsafe abortion as a serious health issue had emerged via the International Conference on Population and Development (ICPD). This conference agreed to address unsafe abortion as a major public health issue but also in terms of an international commitment to women's rights to reproductive self-determination (Sai 2004, p.19). The programme of Action which resulted from the conference provided a comprehensive document detailing rights associated with sexuality, male involvement, violence and unsafe abortion – issues which until the conference had not been part of the international agenda to any great extent (Sai 2004, p.19). The advances made at the ICPD were expanded at the Fourth World Conference on Women, which was held in Beijing in 1995. Of great importance is the fact that at these conferences a human-rights centred discourse was also being formulated around 'sexual rights for women, including the right to say 'No' to unwanted, forced or unprotected sex' (Crossette 2005, p.71)**.** The denial of this right is a highly significant reason for many unwanted pregnancies globally. It is also a significant reason for the women in this study to perform unsafe abortions.

Despite the link between women's sexual and reproductive rights and incidences of unsafe abortion and subsequent maternal morbidity and mortality, the Millennium Development Goals (MDG) do not include any explicit commitment to women's sexual and reproductive self-determination. The reasons for this are detailed in the second chapter of the thesis. However, the result is a commitment to women's health defined as 'maternal health'. The consequence of the non-recognition of women as

people with sexual and reproductive rights in a social sense beyond motherhood, has allowed largely medical and technical means such as contraceptive provision or hospital abortion services, to be seen as the key solutions to women's health problem of unsafe abortion all under the guise of 'maternal' health. This study will demonstrate that the failure of the MDGs to address the social issues of gender inequality as they relate to sexuality and reproduction has serious health consequences, which cannot be solved by contraception. Millennium Development Goal three is dedicated to promoting gender equality and empowering women but again, does not provide any explicit commitment to women's sexual or reproductive self-determination. Instead, the goal focuses primarily on eliminating gender disparity in education.[2] It is of course of very great importance that equality is achieved in global education. However, as a leading global policy on gender equality and women's empowerment, the decision to prioritise education over women's sexual and reproductive rights is regrettable from a health perspective. The decision not to target women's sexual and reproductive rights as an issue of gender equality maintains patterns of severe disempowerment with corresponding health consequences, which some women must continue to endure. The ethnographic evidence in this study will demonstrate the health consequences of failing to directly address women's sexual and reproductive self-determination as a social issue of gender equality. Moreover, it will demonstrate the impossibility of reducing incidence of unsafe abortion by predominantly medical and technical means.

The thesis is broadly divided into three parts, each with its subsequent chapters. The conceptual categories for each part are taken from the work of medical anthropologists Scheper-Hughes & Locke (1987) who provide a theoretical structure based on what they call 'The Three Bodies'. These 'three bodies' are really perspectives or ways of understanding the body and an experience of embodiment. The categories of each 'body' are included as a conceptual guide for the sections.

[2] See Goal 3 Promote Gender Equality and Empower Women – Fact Sheet. UN Department of Public Information – DPI/2650 C – September 2010. It should be noted that the Millennium Goal Three focus on education does not mean that the United Nations is ignoring violence against women. The *UN Trust Fund to End Violence Against Women* has supported programmes in 121 countries. There are specific programmes to reduce female genital mutilation and cutting in Africa. However women's right to sexual and reproductive self-determination was not part of the leading global policy promoting gender equality and empowering women.

They are not intended to be read as rigidly defined or exact; each of the three perspectives of the body can also be seen as having links or merging with the others. I have used the three broad distinctions as a way to assist the reader in understanding the multiple levels of experience which exist within any circumstance of embodiment. Moreover, how these multiple levels are integrated into the social circumstances of unsafe abortion.

The first body is a 'personal body' defined by Scheper-Hughes and Lock (1987, p.6) as a 'phenomenological body' or the 'lived experience of the body-self'. The idea of a personal body in chapter five begins the ethnography of the thesis. I have chosen to begin with a village woman explaining how she and some other local women perform a self-induced abortion. I have done this because I believe it is important for the reader to understand from the first instance, both how the women perform the abortion and also how dangerous it is. I would like the reader to carry this knowledge with them as they advance through the thesis, and through all the various social reasons inherent in the women's lives which explain why they see an unsafe abortion as a necessary social practice. Here the reader is introduced also to the community clinic and the security it offers the local women who attempt abortion. This chapter is a very intimate ethnographic explanation of unsafe abortion from the perspective of the lived body-self of these African women. It provides the first reasons why many women feel it necessary to undertake such a dangerous social practice. The chapter details the intense physical demands placed on women's bodies in rural Africa and why the women see unsafe abortion as a way to maintain what Giddens (1991, p.243) terms as 'ontological security' or a sense of order over their bodies and life circumstances.[3]

Chapter six begins the second section of the thesis with Scheper-Hughes' and Lock's (1987) concept of 'the social body' as its guiding framework. A social body is a way of thinking about relationships among nature, society and culture (Scheper-Hughes & Lock 1987, p.6). In order to understand the social practice of self-induced abortion in

[3] Giddens (1991, p.243) defines ontological security as 'a sense of continuity and order in events including those not directly within the perpetual environment of the individual'. This sense of order experienced by individuals is dependent on people's ability to give meaning to their lives by avoiding events or circumstances which may induce anxiety or be chaotic to the individual. Ontological security also includes having a positive view of self, the world and the future. An unwanted pregnancy can therefore be a significant challenge to some women's ontological well-being.

the Ewe village, a woman's body must be seen not only as a personal body but also as a body which belongs to a series of relationships with other social actors, nature, society and a culture. In large part, women's bodies are subject to systems of social control as they form part of the social body of Ewe society as a whole. Contraception is often not possible for the village women in this study because of social relationships with husbands or male partners who do not allow it. The chapter provides an analysis of the way in which the political economy of village life makes it difficult for some women to refuse to bear children. The village of Abladzo is a self-sustaining farming community and women's reproductive capacity is an inherent part of the mode of production in the local area. The chapter is guided by a Marxist theoretical analysis of the economic mode of production. A thorough explanation of Marxist theory as it relates to this study has been provided in the literature section of the thesis. The chapter shows the way in which the forces of production and the relations of production, what Marx called the infrastructure of a society, combine to enable economic survival in the rural environment. The local women's reproductive capacity forms an aspect of subsistence survival, as children are an important source of labour on the farms (Oppong & Bleek 1982, p.19). However, children also contribute to forms of wealth, security and prestige making it difficult for many women to refuse multiple births.

The Marxist theoretical approach to chapter six is also combined and moderated somewhat by the theoretical influence of the work of French anthropologists Terray (1975) and Meillassoux (1972). They place great emphasis on the kinship relations which typically form the relations of production in self-sustaining agricultural communities such as Abladzo. I have analysed the kinship relations of production within household units in Abladzo to show how these patterns of social relations contribute to unwanted pregnancies. I have used the Marxist notion of contradiction to argue that the practice of self-induced abortion is a form of social struggle undertaken by some local women. However, I have also called on the work of the French anthropologists to explain why the women's resistance to the current relations of production must take the form of unsafe abortion and not a more overt class protest or conflict. I have aimed to show in this chapter why the transformation of the women's circumstances is slow.

Chapter seven continues the discussion of unsafe abortion from a Marxist perspective but turns to an analysis of the historical production of systems of institutions and ideas of the Ewe society, what Marx called the Superstructure. The chapter examines two local myths as examples of the philosophical and religious ideology of the community. These myths show how gender ideology, inherent in the superstructure of the local culture as an element of patriarchal tradition, defines the Ewe female as subordinate and ideally, obedient to the Ewe male. The myths are fascinating from an anthropological perspective. However, they also reinforce patriarchal social values and praxis, and therefore may influence many women to doubt their capacity to transform the culturally defined fertility patterns as the patriarchal values appear as an indisputable social order legitimised by tradition. The chapter demonstrates the powerful influence of social beliefs and values which undermine medical and technical attempts to reduce incidences of unsafe abortion.

The legal institutions are another form of Marx's concept of superstructure. Chapter eight is an examination of Ewe customary law as it relates to the institution of marriage in the village area. However, chapters seven and eight also embrace the work of Turner (1984). Turner's (1984) work becomes important in these chapters because it specifically concerns sexuality. The analysis moves from a Marxist perspective of the social aspects of the economic mode of production and reproduction, to understanding the nature of culturally defined sexual social relationships in the village. Turner (1984) argues that human sexuality is the product of very particular cultural arrangements.[4] Much of Turner's (1984) theory is concerned with the idea that an order of human sexuality exists in any given society and that it corresponds to an order of property and production. He calls this order the 'Mode of Desire'. It is in chapters seven and eight of the thesis that I demonstrate some of the forms and transformations of Ewe social values, beliefs and praxis which operate as the Mode of Desire in Abladzo village and serve to structure, although not completely determine, the sexual and reproductive circumstances of the lives of local women.

[4] In accordance with the ideas of Mead (1949).

In chapter eight I demonstrate that marriage is a key part of patterns of social relations in Abladzo and for many of the women in this study, marriage is a reason for the lack of control they experience over their bodies. Subsequently, it is also a reason to perform unsafe abortions. A traditional marriage in Abladzo involves the payment of bride wealth and the subsequent legal entitlement of a husband's rights over the wife as his property. These rights include sexual rights over her body. While traditional law states that a husband is supposed to be fair to his wife in these matters, coercive and indeed abusive sexual circumstances exist within some marriages. In unison with patriarchal notions of female obedience and male preference for large numbers of children to labour on the farm, as discussed in chapters six and seven, the sexual expectations placed on some women by the institution of marriage make unsafe abortion a necessary form of agency against unwanted pregnancy.

A traditional marriage is of course not the only form of sexual social relations in the village area. Nowadays increasing numbers of young local Ewe are choosing to ignore customary marriage rites and form sexual unions outside marriage. The gradual abandonment of the traditional practice of bride wealth payment, has not however, facilitated the gradual abandonment of all the ideological components of the tradition. Rather, there has been a transformation of the tradition, which can see a woman's sexual obligations to the man remain whether he is, or is not, her husband. This interpretation of patterns of sexual social relations is doubtless in part an effect also of the patriarchal ideologies of obedience and subordination discussed in chapter seven. The new patterns of relations are creating difficult circumstances for some unmarried women in the village area who find themselves unable to refuse male sexual advances in either longer-term relationships or more casual encounters. The transformation of the traditional male role of material provision in return for sexual relations within a marital relationship is seen in new patterns of social relations outside marriage in which material gifts are given to women (Zeitzen 2008, p.164). This in turn can obligate the woman to fulfil male expectations of sexual relations (Zeitzen 2008, p.164). Women who become pregnant under these circumstances may see abortion as a necessary means of avoiding the very severe hardships of single-parenthood. Abortion is also believed to be necessary for some women in order to protect their moral reputation. The chapter emphasises the gender inequalities that remain despite the apparent transformation of the traditional patterns of sexual social relations. The

resolution of the problem of gender inequality would contribute far more to reducing incidences of unsafe abortion in the local area, than medical and technical service provision.

Ewe customary law strictly forbids abortion. Chapter nine examines the systems of social surveillance and sanctions which exist within the community and attempt to ensure that women give birth and are punished for performing an abortion. Strong ideological concepts of childbearing are part of cultural ideas about maintaining local lineages. Some local people see a woman as responsible for contributing to the maintenance of her ancestral lineage. As she was born by ancestral women, so she should bear children. The chapter also examines the agency of some local women who have performed an abortion despite quite severe culturally defined penalties. These penalties include: fines, a ceremonial cremation after death, and shameful disapproval of the community, the elders and the ancestors who observe the actions of individuals from the sky above. The act of inducing abortion must therefore be kept secret. In an Ewe community a woman's body does not belong only to her, but it is also very much a social body. A woman's sexuality and reproductive capacity form an integral aspect of survival and position in the social order for others as well as herself. Thus medical and technical solutions aimed at 'compliant individual bodies' are unlikely to greatly change the incidence of unsafe abortion in the village area.

The third section of the thesis is entitled 'The Political Body'. This is the third of Scheper-Hughes and Lock's (1987) three bodies. Scheper-Hughes and Lock (1987, p.6) define this perspective of the body as 'a body politic, an artefact of social and political control'. This section moves the analysis outward from the immediate circumstances of village life to an analysis of the national and international efforts to reduce incidences of unsafe abortion in Ghana. The chapters in this section view the Abladzo women's bodies as political artefacts to be aligned with global and national health discourses and programmes of action. Each chapter shows the interaction between key national and global policy ideals and practice, and how and why these same ideals and programmes of action fail to improve health outcomes for many of the women of Abladzo village. Furthermore, in a cruel paradox, some of these rural women may even be harmed by the medicalization of their gynaecological ill-health

as it is seen as purely personal medical problems instead of the physical effect of deeply entrenched patterns of gender inequality which require social change.

Chapter ten describes the Ghanaian state's inability to provide adequate healthcare facilities to the majority of Ghanaians, but especially to rural citizens such as those who live in Abladzo. The chapter explains the poor state of Ghana's public health service provision by locating the developing nation within the global political economy and providing examples of the insurmountable economic challenges Ghana has faced since independence in 1957. The chapter demonstrates the way in which the nation of Ghana is enmeshed in global relationships at the level of the body politic. These relationships create discourses and ideological flows about healthcare and its provision which, in turn, must be enacted by the Ghanaian state. However, the ethnographic accounts of this chapter demonstrate that with regard to public sector health efforts to reduce the incidences of unsafe abortion, discourses, policies and programmes of action often do not assist the women of Abladzo. Public health sector medical and technical solutions to an unwanted pregnancy are usually geographically, financially and socially unattainable for many of the village women.

Chapter eleven again examines the Ghanaian state's efforts to improve women's reproductive health. The chapter is an analysis of the *Ghanaian Reproductive Health Plan 2007-2011* formulated by the Ghanaian Ministry of Health. In this chapter, I argue that there are in fact two conflicting discourses on reproductive health for Ghanaian women. There are policies and programmes of action formulated at the level of the body politic in adherence with international human-rights standards of gender equality. These policies, such as the aforementioned *Ghanaian Reproductive Health Plan 2007-2011*, reflect Ghana's commitment to global development goals in the international political arena. However, the ideals of equality and reproductive freedom for women espoused in the plan are contradicted by Ghanaian national laws about marital rape as well as other national discourses which deny Ghanaian women gender equality. The contradiction stems from the conflation of national law and traditional belief structures at the level of the 'social body', as described previously in this introduction. These beliefs are deeply embedded in forms of cultural praxis which serve to produce and reproduce women's inequality as a systemic cultural reality. I argue that the state policies espoused in the *Ghanaian Reproductive Health Plan*

2007-2011, and its advocated forms of sexual and reproductive health do not protect many of the women of Abladzo.

In chapter twelve I have employed the concept of medicalization. This term is derived from studies by critical medical anthropologists. They argue that an overemphasis on biomedical and technical forms of treatment can obscure the social origins of health problems and maintain harmful patterns of social relations (Kleinman 1995, Scheper-Hughes 1992). Medical and technical solutions are advocated as the way to reduce incidences of unsafe abortion in Ghana and to improve women's reproductive health. However, little action seems to be taken to address coercive or violent patterns of sexual relations against women. In this chapter, I provide ethnographic evidence that the women in this study see their ill-health as being caused by gender inequality. The women identify health problems in terms of patterns of social relations not as purely personal random biological misfortune. The idea of gender inequality as a significant aspect of women's ill-health is supported by Avotri & Walters's (2001) study of the health of Ghanaian women, which was also undertaken among Ewe. According to the article, the women understood health in social terms as something that was inseparable from their social roles. In particular, the women were concerned about the way in which their (ill) health was shaped by gender and their relationships with men (Avotri & Walters 2001, p.199). The women in the study describe their ill-health as being caused by insecurity and a lack of control over their lives. This chapter also relies on the work of critical medical anthropologist Scheper-Hughes (1992) who describes 'the social relations of sickness' (Scheper-Hughes 1992, p.174). She argues that biological illness can be an indicator of circumstances of 'sick' or illness inducing patterns of social relations. Therefore, to treat bodily symptoms biomedically, but ignore the deeper social origins of illness is to medicalize social distress (Scheper-Hughes 1992, p.214). In chapter twelve, I argue that the bodies of some village women are being medicalized. There are a significant number of women in Abladzo with gynaecological complaints. Current patterns of gender inequality which I argue likely contribute to these negative health outcomes for the women of Abladzo, are simply not being addressed.

The forthcoming twelve chapters provide the answers to my first research question. *Why do some of the women of Abladzo perform unsafe abortion?* In chapter thirteen,

the focus turns to answer my second research question more fully. *Is the NGO empowering the women who perform unsafe abortion?* I analyse the NGO's impact from a developmental perspective structured around the work of Molyneux (1985). Molyneux (1985) provides clear criteria to assess the degree to which women's interests are expressed in a given situation. The first of these are *Practical Gender Interests* (PGI). These are defined as meeting women's immediate perceived needs (Molyneux 1985, p.233). The second is *Strategic Gender Interests* (SGI) defined as a way to challenge normative gender values and overcome women's subordination (Molyneux 1985, p.233). I argue that currently the NGO serves women's PGI by administering the anti-haemorrhage medication, but does not facilitate their SGI. Here a caveat is necessary. Although the NGO does not advance the women's SGI, the medical assistance, which the NGO provides, is life-saving and greatly appreciated and acknowledged by the local women. Paradoxically however, the continued provision of short-term emergency medical solutions without addressing women's SGI may in fact create the medicalization of their social distress as described in chapter twelve.

Nonetheless, the work of advancing the local women's SGI is not the responsibility of the NGO alone. Nor is it the responsibility of the local women. Through the theoretical ideas of both Sen (1999) *'Development as Freedom*' and Tsey (2011) '*Re-Thinking Development in Africa*' I continue chapter thirteen with the argument that women's strategic interests require multiple stakeholders to engage in critical conversations about traditional values and beliefs which undermine the dignity and well-being of women (Tsey 2011, p.97). I include within the group of stakeholders, those who were responsible for the compromised policy trajectory of the Millennium Development Goals, which diminished global commitment to the sexual and reproductive human rights of women. Despite the inequalities reported in the lives of some women in this study, it should be emphasised that many of the values held in esteem in the local Ewe worldview are qualities such as kindness, fairness, forgiveness, love, patience, and courage in uniquely African ways. I argue that at the level of the 'social body' these higher values, already present in local culture, could be utilised in favour of women's SGI. In addition, at the level of the body politic, gender equality with regard to sexual and reproductive rights for women must return to the international agenda as an issue of critical importance for specific policy

development and programs of action. It is only the empowerment of women, through the development of multiple levels of their SGI that will reduce the incidences of unsafe abortions in rural Ghana. This will of course involve medical and technical solutions, but the efficacy of these must be seen as secondary and supplementary to the real solution, which is greater gender equality.

Chapter Two
Setting the Context

Induced Abortion Worldwide

Induced abortion is the oldest and, according to some, perhaps the most widely used method of fertility control (Royston & Armstrong 1989). Worldwide, between one-fifth and one third of all pregnancies are terminated each year by induced abortions (Jacobson 1990, Henshaw 1986). However, not all induced abortions are performed safely. The World Health Organisation distinguishes between safe and unsafe induced abortion (WHO 2003, pp.12-15). Even conservative estimates indicate that complications associated with unsafe abortions account for 40% of maternal deaths globally (Coeytaux et al 1989, Royston & Armstrong 1989). Of the 68,000 women who die each year due to complications associated with unsafe abortions, the vast majority are women from developing nations. The majority of induced abortions performed in developed countries do not create negative health outcomes for the women. When performed hygienically and correctly, abortion is a very safe medical procedure. In contrast, the induced abortions in developing nations are often performed by untrained individuals or indeed, by the women themselves and may cost them their lives.

Death is not the only cost of unsafe abortion. Thousands of women who survive the procedure suffer serious health complications including: sepsis, haemorrhage, uterine perforation and cervical trauma, which often lead to permanent physical impairment, chronic morbidity, infertility and psychological damage (Coeytaux 1990, McLaurin et al 1991). In addition to the unacceptable health burden unsafe abortion places on women, treating the complications of unsafe induced abortion further strains the already stretched budgets of public health systems in developing countries, where 99% of the world's maternal deaths occur. The WHO (1998) claims that treating abortion complications may consume up to 50% of hospital budgets in developing nations. It is a bitter irony that it costs less to perform medically safe abortion procedures than it does to fix 'botched' abortion attempts (Coeytaux et al 1993, p.134).

Unfortunately, preventing unsafe abortion in developing countries is not a simple matter. Abortion has been, and to a very great extent continues to be a social practice which is stigmatised if not completely outlawed. This results in many women seeking clandestine abortions from unskilled providers or performing a self-induced abortion by means of drinking or administering toxic substances, inserting foreign bodies or instruments into the cervix or by blunt physical trauma to the abdomen. Such methods, dangerous albeit tried and true, are commonly used in developing countries where women face numerous barriers to the provision of abortion services. These barriers include financial issues such as being unable to afford the operation fees for a safe abortion from a public hospital or clinic as well as physical barriers such as a lack of transportation to a public clinic, which may be a considerable distance from the woman's home. This is particularly a problem for many rural women. Indeed, there still exists in many developing nations a lack of public sector abortion facilities and skilled workers to staff them. Moreover, there exist social barriers to women accessing safe abortion services such as 'pro-natalist' community values which prohibit abortion, as well as restrictive national legislation which may be prohibitive or entirely preventative in some countries (Hessini et al 2006).

The International Response to Unsafe Abortion as a Global Health Burden

Although abortion law reform has been taking place slowly since the 1960s, for many years the practice of unsafe abortion has remained little more than a silent statistical reality in the arena of global public health. However, the extent of the contribution that unsafe abortion makes to global maternal morbidity and mortality has more recently come to the forefront of the global public health agenda. Unsafe abortion has largely been recognised as a crisis issue since the 1990s. In 1994, leaders at the International Conference on Population and Development (ICPD) agreed to address unsafe abortion as a major public health issue. This conference is very much described as 'a watershed event' in terms of international commitment to women's rights to reproductive self-determination (Sai 2004, p.19). The programme of Action which resulted from it provided a comprehensive document detailing rights associated with sexuality, male involvement, violence and unsafe abortion – issues which until the conference had not been part of the international agenda to any great extent. In addition, the conference facilitated the involvement of women's rights advocates, government allies, religious leaders and NGOs. It was the first time these civil society

groups were able to add their voices to the construction of an international consensus agreement. It was decided that abortion should be safe where legal and that women who suffer from unsafe abortion have a right to treatment for the complications (Sai 2004).

In 1995, the Fourth World Conference on Women was held in Beijing. As a result, the commitments forged at the ICPD were expanded and governments were urged to work in collaboration with NGOs, international institutions and workers' organizations to 'recognise and deal with the health impact of unsafe abortion…'(Sai 2004, p.19). Furthermore, the conference urged governments to review punitive legislation against women who undertake illegal abortions (Sai 2004). By 1999, the United Nations General Assembly held a review of the 1994 ICPD and appraised the progress of governments in implementing the ICPD Programme of Action. The review also advanced a consensus document which advocated the improvement of abortion health services stating that 'in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that abortion is safe and accessible'(Sai 2004)
[5] The conferences created an increased international presence of advocacy for safe abortion services. Many UN agencies, professional associations and national bodies began to focus on unsafe abortion as a critical health concern. Moreover, the World Health Organisation (WHO) developed technical and policy guidance for safe abortion for health systems addressing such issues as preferred methods, provision of skilled healthcare staff and reviews of legislative barriers to abortion provision. [6]

As previously stated, dealing with unsafe abortion is not a simple matter and despite the considerable advances made in the international policy arena, the issue remains hotly contested. The US government has been, at best, inconsistent with its commitments to reproductive health policies. At the 1984 conference on World Population, the US government announced it would withdraw funding from any organization which provided abortion services.[7] Again in 2001, the Bush

[5] ICPD Programme of Action paragraph 63(iii).
[6] World Health Organisation Safe Abortion: Technical and Policy Guidance for Health Systems. Geneva: WHO, 2003.
[7] This withdrawal of support by the US is known as the 'global gag rule' and had serious implications for public health in developing nations.

administration withdrew from previous commitments concerning sexuality and reproductive rights (Sai 2002). Furthermore, despite the emergence of the exalted Millennium Development Goals (MDGs) in the year 2000, an explicit commitment to the reproductive rights of women was strangely absent. It was replaced only by more general promises of gender equality and improved maternal health (Crossette 2005). This was a severe setback from the advances made at the conferences described above where a human-rights centred discourse was also being formulated around 'sexual rights for women, including the right to say 'No' to unwanted, forced or unprotected sex' (Crossette 2005, p.71). The denial of this right is a highly significant reason for many unwanted pregnancies globally. Put simply, reproductive health was not adopted as a Millennium Development Goal because it is too contentious. In addition, NGOs and international institutions were this time excluded from discussions. Crossette (2005, p.76) details the way in which the United Nations Secretariat decided to maintain the 'greater coherence' of the MDGs by not 're-opening the mess of Cairo' (ICPD). Despite the advances made at the 1994 ICPD, there had been fierce opposition both from the sidelines and from official delegations, some with Vatican support or the backing of conservative US and Islamic governments.

Therefore, as a result of considerable political pressure, the MDGs include the vague promotion of gender equality and empowerment of women and a commitment to the improvement of maternal health. Nafis Sadik (2004 cited in Crossette 2005, p.76) who chaired the 1994 ICPD in Cairo, argues that 'repeated calls for gender equality are meaningless without reference to sexual and reproductive health …..[and] women's right to make decisions'. Clearly the international political climate is not ready to accept explicit policy protecting women's sexual rights. The attempts in reducing the health burden from unsafe abortion have thus been directed largely through the MDG of improving maternal health, and in a practical sense have focused on the provision of methods of contraception; now described euphemistically as 'family planning'. There has also been attention given to the expansion of abortion services and the training of healthcare staff. This focus very much positions the issue of unsafe abortion as being largely solved by medical and technical means and minimises global attention on the significant part that unequal sexual social relations play in the health burden of unsafe abortion worldwide.

Despite these deep political undercurrents which largely determine international policy output about abortion, efforts to reduce incidences of unsafe abortion have seen positive results in some global regions. Overall, the global number of unsafe-abortion-related maternal deaths from all causes has declined by one-third since 1990. These figures are from 69,000 in 1990 to 47, 000 in 2008 (Ahman & Shah 2011, p.123). However, the pace of decline varies greatly from region to region with the risk of death from unsafe abortion being highest in Sub-Saharan Africa. The WHO illustrates the trends in the unsafe-abortion mortality rate revealing the annual change or reduction rate in Africa is just 1% whereas Asia and Latin America have shown rates of decline of 4% and 6% respectively.[8] Indeed, it is estimated that 99% of all abortions carried out in Africa are unsafe and the risk of death is one in every 150 procedures (Brookman-Amissah & Moyo 2004, p.228). This is by far the highest in the world. The MDG number 5 has, consequently, had almost no impact on rates of unsafe abortion in Africa. The WHO's analysis demonstrates the trend for abortion mortality ratios to gradually decrease over time. However, this decrease was only noticeable in Africa between 2003 and 2008.[9] Africa had the highest levels of maternal mortality associated with unsafe abortion as well as the highest levels of maternal mortality overall for the entire period from 1990 to 2008 (Ahman & Shah 2011, p.123). It is a grim statistical reality that of the previously mentioned 68,000 deaths from complications associated with unsafe abortion worldwide nearly half are in Sub-Saharan Africa (Wolf 2004, p. 99).

Unsafe Abortion and Africa's Response

African nations have made national and international commitments to addressing these critically high levels of mortality and morbidity associated with unsafe abortion. All African countries have signed the Programme of Action of the ICPD in 1994 as well as the Platform for Action from the Fourth World Conference on Women in Beijing. There have also been regional African commitments to addressing the issue of unsafe abortion such as the 2003 Action to Reduce Maternal Mortality in Africa: A Regional Consultation on Unsafe Abortion at which a cross-section of community leaders, ministers, women's advocacy groups, NGOs, religious organizations and gynaecologists and midwives discussed unsafe abortion in Africa. Here the aim was

[8] See appendix #1
[9] See appendix # 2 for table of global unsafe abortion mortality ratios.

to develop strategies for supporting women's right to safe abortion and related services (Wolf 2004). In addition, in 2007 the African Union Conference of Ministers of Health agreed to adopt strategies to reduce unsafe abortions 'by providing services to the fullest extent that national laws would permit'(Hill et al 2009, p.2017). The practical outcome of this commitment is an increase in training for abortion service providers, improving facilities and technical equipment and educating communities on the availability of services. It should be noted that the impact of these commitments are very much dictated by the degree of liberality associated with national abortion laws.[10] The more restrictive the national legislation about abortion, the less a government is obliged to provide improved abortion services.

However, overall the African continent has liberalised its abortion laws in recent years, largely due to international pressure and supported by local advocacy groups (Hessini et al 2006). In general, the law reform and commitment to policies that enhance women's well-being in Africa was initiated in Anglophone countries and tended to mirror the changes made by former colonial powers. The trend has been to loosen bans on abortion and to include broader indications. These legislative changes are certainly significant. However, they really represent the beginning of truly addressing unsafe abortion in Africa because in many nations the legislative changes which occurred ten years ago have only recently begun to be translated into national programmes of action. Moreover, such programmes are highly dependent on a commitment of continued political good will and financial resources.

Abortion Law in Ghana

The Ghanaian law on abortion changed in 1985 from a prohibitive and punitive stance on abortion to a more liberalised approach.[11] The original abortion law in Ghana was a reflection of colonial relationships being fundamentally based on the old British Statute 'the Offences against the Persons Act 1861' (Morhee & Morhee 2006, p81). This act essentially prohibited abortion. However, the liberalised current law provides that abortion is a criminal offence regulated by Act 29, section 58 of the Criminal

[10] See appendix #3 for table of African Abortion laws (Hessini et al 2006).
[11] The punitive stance taken by the Ghanaian government was very strong. Ghanaian women have previously the faced the death penalty and up to ten years' imprisonment if convicted of illegal abortion. See Bleek et al (1986, p.335).

Code of 1960, amended by PNDCL 102 of 1985 *except* when caused by a registered practitioner practicing in a government hospital or a private registered clinic, in the following circumstances:

a) Pregnancy is the result of rape or defilement of a female idiot or incest and the abortion is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request;
b) Where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such a woman consents to it or if she lacks the capacity such consent is given on her behalf by her next of kin or the person in loco parentis;
c) Where there is substantial risk that if the child were born it may suffer from or later develop a serious physical abnormality or disease (Morhee & Morhee 2006, p81).

The reproductive health policy of Ghana on the reduction of unsafe abortion was for many years largely focused on the promotion of family planning, contraception and post-abortion care, but not on the safe provision of abortion services as recommended by the WHO (Morhee & Morhee 2006). However, more recently reproductive health policies have included the provision of abortion, and service protocols are being developed. Levels of unsafe abortions are still high in Ghana and some data suggests that there are at least 19 abortions for every 100 pregnancies and that more than two-thirds of abortions are conducted outside the formal medical system (Ahiadeke 2001, p.98).

A Profile of the Republic of Ghana

The Republic of Ghana is located on West Africa's Gulf of Guinea just a few degrees north of the equator. It borders the North Atlantic Ocean to the South, Burkina Faso to the North, Cote d'Ivoire to the West and Togo to the East. It has a total area of 238 540 square km of which 230 020 square km is land, the rest is covered by rivers and lakes. A large tropical rain forest belt produces most of the country's cocoa, minerals and timber. Low bush, park-like savannah and grassy plains cover the north of this belt. Parts of Ghana are rich in natural resources such as gold and diamonds. However, agriculture has traditionally been, and continues to be, the mainstay of the economy with cocoa beans and cocoa products remaining dominant exports.[12] Agriculture employs 60% of the workforce and accounts for 37% of the GDP. [13]

[12] WHO Global Atlas on Traditional/Complementary and Alternative Medicine (2005, p.19).
[13] Ghana Web http://www.ghanaweb.com/GhanaHomePage

Formed from the merger of the British colony of the Gold Coast and the Togoland Trust Territory, in 1957 Ghana became the first sub-Saharan country in colonial Africa to gain its independence. In the years following independence, Ghana experienced a period of political instability arising from corruption and mismanagement. However, it now is a fully functioning democracy.[14]

The country is divided administratively into 10 regions and 110 local districts and has a population of 24.5 million people drawn from one hundred ethnic groups, each with its own language.[15] However, English is the official language, a legacy of colonial rule. The GDP per capita is approximately US$1385 and the average life expectancy is 57.1 years (Tsey 2011, p.14). As suggested by Ghana's GDP and life expectancy statistics, life can be very hard for a great many Ghanaians and the health status of much of the population remains very poor. Like other developing countries, Ghana continues to search for ways to meet the healthcare needs of its growing population. In particular, the government seeks ways to assist rural Ghanaians for whom accessibility and affordability of state healthcare is simply out of reach. Notably, rural citizens make up 70% of the population of Ghana.[16]

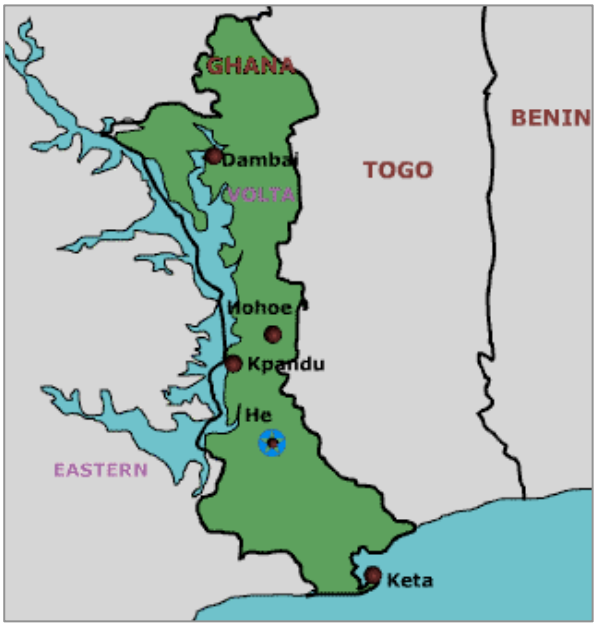
Western medicine was introduced to Ghana as early as the first missionary contacts. However, despite being the medicine of choice for the state and the urban elite, western style pharmaceutical medicine provides no relief for the vast majority of Ghana's people. For rural folk, the traditional health practices, medicines and spiritual therapies provide a way to treat, diagnose and prevent illness. This is a fact officially recognised by the Ghanaian Government as well as international bodies such as the World Health Organisation (WHO). In 1999, the Traditional and Alternative Medicine Directorate was established at the Ghanaian Ministry of Health. The vision was to support traditional and alternative healthcare in order to improve the health status of all people living in Ghana. [17]

An additional form of healthcare support for Ghanaians is provided by Non-governmental organizations (NGOs). Many of these have their roots in Ghana's

[14] http://www.countrywatch.com/country_profile.aspx?vcountry=66
[15] Of these groups however, seven major ethnic groupings can be found. These are the Akan (45.3%), Mole Dagbani (15.2%); Ewe (11.7%); Ga Adangbe (7.3%); Guan (4%); Gurma (3.6%); and Grusi (2.6%), (Census 2000).
[16] See Tabi et al (2006, p.53)
[17] See WHO (2005, p.21) Global Atlas of Traditional, Complementary and Alternative Medicine – Text Volume.

experience of colonisation. However, after experiencing serious economic difficulties in the 1970s and 1980s Ghana became dependent on international aid packages offered by the International Monetary Fund (IMF) and the World Bank. These international bodies subsequently instigated Structural Adjustment Programmes (SAPs) in the 1990s which placed the Ghanaian state under stringent debt repayment obligations leaving little of the national budget available for state sector public services such as health and education. It was during this era that Ghana experienced the rise of the NGOs. These international groups were able to provide support for Ghanaian social actors where the state simply could not. The presence of NGOs remains significant in Ghana today where they continue to provide assistance to the people.

The Volta Region



As stated above, Ghana is divided into 10 administrative districts. The fieldwork component of this research was undertaken in the Volta Region, which is located in the South-East of Ghana. The region lies east of the Volta Lake. Its capital is the city of Ho. Most of the region North from Ho was part of the German colony of Togoland while the Southern-most part was originally colonised by the Danes and later transferred to the British where it was administered as part of the Gold Coast and later became part of Ghana.

Despite boasting very beautiful landscapes, the Volta region does not have the natural mineral or timber resources found in other districts in Ghana. It has high levels of unemployment and poverty. It is widely argued that the construction of the Akosombo Dam on the Volta Lake has contributed to the death of the cocoa industry in the area causing a significant increase in rates of social deprivation. In addition, the construction of the dam has not brought the promised benefits to the fishing areas in

the region. Most of those living in the area lack access to piped water, electricity or a flush toilet.[18]

The Ewe Ethnic Group

While almost all the ethnic groups are represented in the Volta Region, it is the traditional home of the Ewe people who make up 68.5% of the total population of the area.[19] In more recent times the Ewe have referred to the Volta region as 'Eweland'. The predominant language spoken in the region is Ewe, pronounced [Éve]. There are marked local variations in dialect which make it difficult for people of one area to understand others even within the Volta Region. This is perhaps a reflection of the fact that until the arrival of Europeans, the Ewe never formed one political unit. The language can be broadly grouped into three main dialects: Anlo, Vedome and Tongu.[20] The original home of all Ewe is traced traditionally to Oyo in Western Nigeria from where they are believed to have migrated into their present countries of Ghana and Togo in the seventeenth century.[21] There are vast variations in many aspects of cultural traits among Ewe. These are evinced in language as previously mentioned, but also in musical forms, dance and belief structures. It would certainly lead to inaccuracies if I attempted to generalise about Ewe peoples even within the Volta Region itself. This study is therefore limited to one Ewe village and its two neighbouring 'mini' villages in the Volta District. I have deliberately not disclosed the specific tribe or lineages in this study. This was not done because of a lack of knowledge or information about the tribal affinities of these people but because I did not wish to risk breaching their confidentiality in any way. Thus, as often as possible I have used terms such as 'local Ewe' when referring to the people or culture in an attempt to remind the reader of the distinctions which exist within the different tribes of Ewe. I accept that at times this is a little cumbersome but it ensures the confidentiality of the village which is of paramount importance considering the subject matter of this study. I have also given the village the pseudonym 'Abladzo' in order to protect the identities and privacy of those who have participated in this research. Likewise, the names of nearby villages and towns mentioned are real places

[18] See the Regional Minister, Volta Regional Coordinating Council http://www.ghananation.com/Volta/?blurb=132
[19] See Government of Ghana Official Portal http://www.ghana.gov.gh
[20] See GhanaWeb, 'Country Information' http://www.ghanaweb.com
[21] See Nukunya (1969) Introduction.

but have been given fictional names to ensure the confidentiality of all who took part in this study.

The Ewe District Profile

The village of Abladzo is located in an Ewe district. The district is largely undeveloped and most of its inhabitants are poor. The road network is very poorly developed and most places in the district are inaccessible during the rainy season. The nearby town, Sukli, used to be a major trading and agro-industrial centre in the Volta region until the construction of the Volta Dam led to a decline of fisheries in the area. Currently, the primary socio-economic activities in the area are civil service work, food processing, animal rearing, farming and trading.

Politically, there are forty-two electoral areas which are zoned into eight town councils. A District Chief Executive who is appointed by the Ghanaian President heads the district. The local District Assembly is the highest decision-making body and operates through various committees and its general assembly. There are nine traditional areas, each of which must compete for its share of the modest district development package. Traditional authority structures also exist in the area. A Paramount chief oversees the district while traditional chiefs and elders act as custodians of each of the various communities. A Chief and a Queen Mother are usually selected from the senior members of the lineage or several lineages which are considered to be the founders of the community. These positions of authority are called *stools* and are ancestral property given to a male and female member of the extended family respectively. Decisions taken by the chief are normally taken in consensus with community elders and based on the legitimacy of traditional authority sanctioned by Customary Law. [22]

The district is divided into six sub-districts for official health delivery which are overseen by a Social Services sub committee co-ordinating health services. There are two hospitals in the district. In addition to the hospitals there are nine official healthcare centres.[23]

[22] See 'Country Studies Series' Federal Research Division Library of Congress.
[23] It should be noted that these are very limited in qualified staff and resources.

Abladzo Village Profile

The village of Abladzo has a population of approximately 350 people. Its neighbouring villages Aduba and Azi Detsi are home to another 400 people in total.[24] The Abladzo Ewe are said to have come from the town of Notse in Togo and to have been in the area for the last 600 years after walking backwards en masse out of Togo. The local oral tradition has it that the Ewe people lived under the oppressive reign of an evil Togolese king.[25] The king ruled that all his subjects should live inside the city which was surrounded by tall walls. The Ewe people however, made an escape plan. Whenever the women did the washing, they would throw the waste water on the walls until gradually the wall became softer and softer and they could break through. [26] They then walked backwards out of Togo in order to confuse the king's soldiers who would pursue them by tracking their footprints on the ground. The Volta Region of Ghana is very close to Togo and the plan was successful. The Ewe people settled and have remained in the area ever since.[27] The villagers at Abladzo are very proud of their ancestors' cunning and courage. The local people like to sing and enact this history, walking and dancing backwards.

Nowadays, the people live in the local village in patrilineal descent groups. They are exogamous by custom. Residence is traditionally patrilocal but increasing numbers of young couples and their children live in neolocal residence. The village is made up of agnatic clusters, a few of whom are reputed to be able to trace their ancestry back to family members who were the original founders of the community.[28]

The main occupation of almost everyone in the village of Abladzo is agricultural work. Most people start work on their arable lands before 7am and finish around 4 or 5pm. For a great many people this work is the basis of a subsistence existence, although some of those with larger land holdings grow crops for export to Chad and

[24] Statistics are taken from year 2000 official census and calculated at a growth rate of 3%. Information provided by statistics department of the local District Assembly.
[25] Personal communication with village locals and the Director of Ghana KINDNESS NGO.
[26] Washing is almost without exception done by hand in Ghana and equally almost without exception, by women.
[27] A more extensive version of this oral history can be found in Tsey (2011, pp. 30-34).
[28] Agnatic kinship refers to a system of patrilineality.

Togo. [29] The climate of the area allows four main crops to be cultivated: peanuts, maize, cassava and chillies which the locals refer to as 'peppers' and are ubiquitous in high concentrations in all cuisine of the region. Cassava is the most economical of all tropical root crops to produce. It will grow in almost any soil conditions and generally gives high yields. However, 'cassava contains less than 1 percent protein and considerably less iron and vitamins than cereal grains' (Godfrey et al 2004, p.41). It is this root vegetable that forms almost the sole basis of every meal of those living in and around Abladzo. Local villagers are so dependent upon this crop that despite its poor nutritional content, they call it [*agbeli*] 'life exists' or sometimes 'saviour'.

The agricultural work is extremely arduous and the average daily temperatures in the village are around 38 degrees Celsius with high levels of humidity. The picturesque landscape provides little shade for those who must cultivate.[30] The farming methods are not highly mechanised and most locals work predominantly with shovels and cutlass and weed by hand. Inevitable injuries occur as sandal-clad farmers negotiate these farming implements and the various snakes and scorpions which also occupy the fields of maize and cassava.[31] In addition, cassava is a thorny crop and many local people suffer from injuries to their skin which can become infected or ulcerated in the tropical heat. [32] Unfortunately, the financial rewards of the back-breaking agricultural labour are very limited; the average income of a family living in Abladzo is around 2,000 Ghana Cedis annually.[33] Locals stated that they receive approximately US $1 per bag of exported [*gari*] cassava flour.[34]

[29] I arrived in Abladzo in September which is production time for the cassava crop. My first experience of the African village was witnessing the harvesting, peeling, washing, grinding and removal of starch from the cassava before it is fried and turned into a flour called *gari.* It is then bagged for export. Everything I saw contradicts western media portrayals of 'hungry Africans waiting for aid from the west'.
[30] Only the very young and the very elderly are exempt from farming.
[31] The presence of these animals is considerable. While at the village I saw at least three snakes, one of which was an extremely large cobra making its way through the grass. In addition, on hearing that I had never seen a scorpion, an enthusiastic local brought five scorpions which he had captured alive from the bush that morning and tipped them onto the breakfast table for me to examine more closely.
[32] For an excellent diagram of farming risks in Africa but also relating specifically to agricultural work in Abladzo, see Godfrey, Parry, Mabey & Gill (Eds) (2004 , p.41).
[33] Under current exchange rates this is NZD $1353.97 a year. (http://www.xe.com/ucc/convert/?Amount=2000)
[34] For a photograph of the bagged *gari* product, see Appendix #4.

Despite these very trying life circumstances, the vast majority of village people are very cordial and good-natured. Indeed many locals very much enjoy a good joke. It was always a genuine pleasure to be in their company.

Chapter Three
Methods and Fieldwork

Methods

The original aim of this research was to find out 'what medicine means' to the people of Abladzo village in rural Ghana. Of course, by the title of this thesis it is obvious that the original research question underwent some reformulation in the context of fieldwork. I am learning that this is often an outcome of anthropological research intentions. However, I would like to explain the process of reformulation because it was a valuable fieldwork lesson in method for me. My research began when I had been browsing on the Internet and discovered a website about an international development project by an NGO whom I shall rename as Ghana KINDNESS in order to protect the confidentiality of the village and the participants in this research. The work of Ghana KINDNESS was of great interest to me. The project had established itself in villages in rural Ghana where it has been undertaking various development goals in partnership with the local people.

The website detailed how primary medical treatments were offered at the clinic established by the NGO. In addition, it explained how the project is empowering local people by training young Ghanaians from the local area to become healthcare workers and educators while they work at the clinic. To some degree, I had always looked for positive outcomes for subaltern social actors as a basis upon which to formulate a research question. I find it inspiring to research and write about the advances that can be made in this area when attention is given to notions of social justice. So the policy discourse of development projects with its 'mobilising metaphors' went to work on my social conscience and the Ghana KINDNESS project was simply irresistible (Mosse 2005, p.230). After email contact with the various parties who manage and fund the clinic, I was told that the local people also like to use herbal medicine in accordance with their traditional values. I then had two epistemologically different medical systems to analyse and so the research question of 'what medicine means' still seemed appropriate at that stage. I obtained approval for the study from the University of Canterbury Human Ethics Committee and I flew to Ghana. I travelled

out of Accra, the capital city, to the village of Abladzo. The clinic and its surrounding areas were my home and fieldwork sites for the next six months.

In large part my fieldwork method was participant observation. This was particularly true at the beginning of my stay at the clinic because I understood so little about anything of life in rural Ghana. Every morning I would rise at about 6am and have a bucket bath outside, as was usual for local people. I would then have breakfast with the other international volunteers, when any were present at the clinic, and we would all get to work. For me, initially this meant watching what was happening at the clinic and talking to the volunteers and local staff. Africa has a different concept of time and getting things done and so I soon found that a large part of my day was spent sitting under the trees in the clinic compound and talking to the various individuals who would call into the clinic, not for treatment but just to say *efoa?* [hello, how are you?] or to pass by the clinic compound on their way to their farms which were located behind the clinic on communal land distributed by the local chief. It was during this time that I discovered that what was described to me as the local Ewe tradition of herbal medicine by the project founders was in fact largely connected to the practice of Vodun religion. Frankly, to me one of the most terrifying things on this earth was the idea of being possessed. Now I seemed to have plenty of opportunity to overcome this fear as people were being possessed from time to time in the local area and it seemed impossible not to bump into them in the course of everyday life.[35] I arranged for a translator and proceeded to make contact with research participants from the local village, largely by snowball technique.

The people were very kind and many told me a great deal about their religion. I actually did begin to overcome my fear of possession as I understood more of the principles behind the rituals and beliefs of the locals and how these were largely misrepresented by colonial interpretations which had come to dominate my limited knowledge of Vodun. However, I eventually chose not to pursue the herbal traditions and Vodun religion as an aspect of my thesis for two reasons. Although many people were happy to teach me about Vodun, there were others who were displeased with an

[35] This happened mostly at ritual gatherings of Vodun groups such as funerals, which I was invited to attend. In addition, on one occasion a woman who had been possessed was running down the road past the clinic. Local villagers were in hot pursuit and were trying to bring her back to the shrine leader to help her.

anthropologist asking questions about the Vodun. Many people believe that 'white people' have supernatural powers which can drain the Vodun spirits of their power and thus, some villagers feared my inquisitiveness. Within the context of the historical relationships of colonisation, I respect that these people did not wish to share their spiritual world with a white stranger. Fearful people were not the majority however, and those who spoke to me, told me so many wonderful things but I was also concerned about being the author of another thesis from the west which promulgates the idea that African life is dominated by the supernatural and, in particular, that I would be unable to provide an accurate account of these supernatural beliefs. There are postcolonial critiques of western anthropological accounts of spiritual aspects of African medicine. Such critiques are often offered by African academics and must be given serious consideration (Konadu 2008). Thus, I was very worried about writing a thesis about herbalism and Vodun because I simply did not have enough knowledge of the subject material to truly represent an adequate picture of the experience of Vodun that the local people live. Nor did I have enough time to develop this knowledge. To many of the people in the village, the spirits are a most sacred aspect of life and form a relationship of utmost importance. I could not in good conscience write about something sensitive and sacred with inaccuracies or presumptions. I thus felt it most ethical not to include the Vodun or magic or witchcraft in my research.

As I have stated, my initial interest was in the primary medical treatment for local people and although there were individuals who received allopathic treatment successfully from the clinic, the concepts of 'what medicine means' to the local social actors were intricately woven into praxis and belief about all things medicinal. This made it impossible for me to write about the villagers impressions of the clinic without including the traditional religion and herbal medicine. It was a kind of ethnographic 'catch 22' and I was fast losing my original research question. The other aspect of my original interest in the clinic as a development project was the effort made to empower local people through training and education initiatives. I began to investigate one group of local people whom I shall call the *Sodzo* women. It was supposed to be the role of these local women to work as health educators in the local community and to teach others about hygiene and sanitation, sexual health and child nutrition. However, as I talked with various local social actors I discovered that this group of women were almost disbanded and did not really do very much in the way of

health education in the community at all. I had asked the director of the clinic to explain to me why this initiative had failed and he agreed to me recording the conversation. The reasons for the failure were multiple and complex, as is so often the case in development projects. However, in asserting that the women were simply not able to be a good example to others in the community because of the difficulty of their own life circumstances, the director told me the story of one *Sodzo* woman who had died from self-induced abortion. My initial response was one of exasperation. It seemed that even the very people whom I had imagined as being empowered by this project were often not, and that even they were dying from desperate, clandestine health practices against the perils of which they had been recruited to educate others.[36]

There had been references to the act of self-induced abortion in many conversations with different people at different times since I had arrived at the clinic. I regret to admit that I had been somewhat indifferent to these because self-induced abortion did not fit my preconceived ideas about what my research would entail and perhaps the subject unsettled me somewhat. It was a very timely two or three days after my conversation with the clinic director that one of the clinic trainees simply started to tell me about the practice and extent of self-induced abortion in the local area. I was surprised because we had been talking about something else entirely and she volunteered the information without my request. The clinic trainees all spoke English well and the initial information shared by the trainee about the social practice of unsafe abortion in the local area was fairly comprehensive, particularly with regard to the methods used by the women who choose to abort unwanted pregnancies. A key part of the conversation forms the beginning of the ethnographic chapters of this thesis, as back in the field it formed the beginning of my desire to reformulate my research questions and try to understand the social practice of self-induced abortion in Abladzo. My research questions became very clear. W*hy are some of the women of Abladzo performing unsafe abortions?* And *is the NGO empowering these women?*

[36] It should be noted that although many aspects of the project in which I had interest experienced difficulties, there were other successful outcomes such as supplying clean water to the villages and improving the skills of local traditional birth attendants. It is not my intention to attribute any sense of failure to the NGO who have achieved much in partnership with the local communities and are widely respected.

From this point onward my fieldwork methods were more direct. Initially, I simply sought as much background information as I could by paying far more attention when the topic of unsafe abortion emerged in conversations. Although I was unable to speak Ewe, the local language, I was frequently in the company of the clinic trainees who would always translate conversations with the local people and in the evenings frequently explain situations or events which had occurred during the day. For the first three months there was no electricity available in the local area and evenings were often spent sitting and talking with those who lived and worked at the clinic and also any of the frequent visitors from the nearby villages who would come to the clinic compound to socialise in the late afternoon and evenings when their cultivation work had been completed for the day. Through this kind of participant observation and 'deep listening', I was then able to ask questions about the circumstances or events discussed (Anderson & Jack 1991). These conversations made the research possible because they allowed me to gain enough information to feel sure that I had sufficient understanding of unsafe abortion in the local area to interview local women adequately and sensitively. These conversations also gave me assurance that this was an issue about which I could legitimately write my thesis. I learnt that it was my job to truly observe what was happening in social praxis and eventually to write an ethnography of an issue which was actually present in the local community and not just a website representation or a good theoretical issue from an academic perspective. Within this context of 'learning to listen' I began to embark on an effort to document what some of these local women experience with regard to unsafe abortion, despite the fact that such experiences lay largely outside the boundaries of usual conversations with foreign visitors to the community clinic (Anderson & Jack 1991, p.11).[37]

Fieldwork

After the subject matter of self-induced abortion began to emerge from the information I obtained from participant observation and its resulting conversations, I wanted to speak to women who had experienced self-induced abortion. When I informed the director of the clinic he told me that he could arrange interviews for me

[37] It is possible that my success in obtaining in-depth conversations with the women lay partly in what Beattie (1964, p.87) describes as 'stranger value'. He argues that being a stranger is an asset and that often people talk more freely to an outsider, as long as she is 'not too much of an outsider'.

because it was from him that the women sought help when they came to the clinic late at night so as not to be observed by others. The clinic received patients who had tried to abort pregnancies themselves and were haemorrhaging. The director told me that he would ask some women he knew if they would agree to speak to me. I was very fortunate that they agreed. Most of the women did not speak English and I did not speak Ewe so the director also functioned as the translator for my interviews. In some respects this was very good because it maintained a high degree of confidentiality in the interview. The women only came to the director because they trusted him to keep the abortion a secret. Self-induced abortion is a forbidden practice in the village. Moreover, many of the women had already told the director much about the personal circumstances which led to them inducing abortion so there was less of a problem in him translating and sharing these with me. The women may have been less forthcoming if a different translator had been used.

However, I am also aware that despite the advantages I have described in the previous paragraph my reliance on the director to recruit and translate the experiences of the women may also be of methodological concern to some readers. A critique of these methodological circumstances is not without its justifiable basis and so I believe it necessary to explain my acceptance of the director as the 'gatekeeper' to my participants and the experiences they shared. Firstly, without the director I was unable to recruit any additional participants who had performed a self-induced abortion despite my inquiries and requests of local people such as the senior local midwife with whom I lived at the clinic on a daily basis or the clinic trainees. I believe I had a good relationship with these people but my request may have been simply beyond the level of trust I had managed to build in the relatively short time I had known these people. Such is the secrecy associated with the practice. Alternatively, and in accordance with what they told me, these people may not have known anyone suitable with whom I could speak. Ultimately, without the director I was denied access to this aspect of local life. Access to people and material resources in the local area depends very much on personal relationships and reputation. Obviously as a foreigner and new-comer to the local area who would eventually return to my country of origin, my opportunities to access people and things on the basis of my own good reputation were very limited. However, as the director had explained to me with regard to another matter, he had had many years to establish a good reputation. The director

called me *vinye* Nicole. This means daughter Nicole, and I believe that my access to the participants who had performed unsafe abortions was purely on the basis that the director trusted me and the women trusted the director and, in turn, spoke to me as a favour in gratitude for the assistance they had received from him.

A more sceptical reader may reasonably question the women's ability to refuse the director's request especially as he was in charge of the local medical clinic. However, there were certainly other people at the clinic who could, and sometimes did assist a person in need of medical assistance without the director's knowledge, should they wish. Therefore, I believe that the women availed themselves of the director's medical assistance and subsequently agreed to participate in my research because they trusted the director and genuinely wished to be a part of the study. Notably also, the director demonstrated a high degree of integrity with regard to the privacy of the women. Although I cannot know the accuracy of his translations, I did notice that he provided me with no further information about the women, their lives or personal circumstances than what they themselves had told me in the interview process despite the fact that he knew the women and their life circumstances quite well. Again, this adds to my belief that my research was able to benefit from a relationship of trust which had been established between the director and the women.

The nature of the sexual experiences of the participants also presented additional ethical considerations to this study. The local women interviewed described their experiences and those of other local women as frequently involuntary, coerced and sometimes violent. This created a need for much greater sensitivity during the interview process but also created issues to consider in the final written ethnographic accounts of the thesis. There exists no basic agreement on a definition of violence against women (Heise 1993, p.171). However, many texts take the 1993 United Nations Declaration of the Elimination of Violence against Women as a benchmark (McIIwaine 2008). Its Article 1 states that gender violence against women can be defined as '*violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private*

life'(McIIwaine 2008, p.445).[38] Heise (1993, p.171) states that rape, battery, homicide, incest, psychological abuse and sexual harassment constitute examples of individual acts of gender violence. However, she also argues that violence must also be seen as present in institutionalised forms of sexism which severely compromise the health and well-being of women. She includes in this category a lack of safe access to contraception and abortion, as well as laws and social policy which perpetuate female subordination.

The women in this study described their sexual experiences and those of the lives of friends or other women they knew as being interwoven with violence. They described circumstances from involuntary or coercive sexual relations to being raped. The thesis addresses these varying degrees and forms of violence as directly translated to me. Sometimes women used the words 'by force' which is a common expression in Ghanaian English to mean anything from 'to do something unwillingly' to in fact 'having no choice in the matter at all'. During the interviews I did attempt to clarify these differences in degrees of violence, particularly with regard to the use of terms such as rape. I trust that the final thesis reflects this attention to the degrees of violence relating to the social practice of self-induced abortion. However, by no means do I wish to minimise or trivialise the participants' experiences as I do not doubt their accounts, nor do I feel that the women exaggerated their experiences in any way. If anything, I believe their accounts to be given conservatively with regard to respect for their culture and the social relationships they hold dear. I also trust that the ethnographic details of coercion or violence are an acceptable indication of current social practice among a significant number of local persons and I believe that the subsequent social issues discussed are of relevance. This may be particularly so in consideration of Heise's (1993, p.182) claim that there exists little recognition of the problem of violence within mainstream developmental organizations and especially those dedicated to health . [39]

[38] McIIwaine (2008, p.445) also notes that Article 2 of the declaration states that such violence may occur in the private sphere and within 'traditional' practices and may thus have a degree of invisibility.
[39] Heise (1993) cites the Canadian NGO MATCH International as the exception to this.

Data Analysis

The process of analysis of the data from the field was greatly simplified by the fact that the information was so consistent. While individuals provided differences in details of their personal lives, the key themes relating to why they considered it necessary to perform an unsafe abortion were the same. The degree to which they felt empowered by the local clinic was also similar. It could be argued that this may be because of the small number of participants interviewed. However, many of the same themes were discussed in the stories I heard in the first three months of being in the local area. Moreover, other men and women who had not performed an unsafe abortion but were interviewed about abortion and local history and traditional law, also confirmed the same themes.[40] I feel confident that the themes chosen were correct with regard to the people I spoke to and the data I obtained. The trustworthiness of the data in this study can also be indicated by the thorough use of ethnographic material from the women's accounts. These accounts can in multiple cases be cross referenced with other women's accounts throughout the thesis and thus provide a foundation upon which judgements of social reality may be made with some degree of accuracy (Guba & Lincoln 1985, p.316).

In addition, almost constant use of triangulation was made during the collection of data in this study. I knew so little about the social world of this tribe that I was constantly checking that I had understood aspects of participant observation data by asking various people if what I had understood was accurate (Denzin 1970, p.310 & Decon et al 1998).[41] These people included the male and female clinic trainees with whom I spent many hours each day as well as a young man who was a teacher in a local school. The man had initially been assigned to me to provide translation services during my investigations of traditional medicine in the local area. Although he was Christian, his family and his wife's family, were staunch adherents to the traditional Vodun religion. He was also reputed by local people to be an intelligent, honest and hardworking young man. Thus it was generally agreed at the clinic that he would be suitable. After these interviews, I had maintained a good relationship with the man and he was always very helpful in explaining and clarifying information and data I

[40] More information about these participants and my reasons for selecting them is detailed in a forthcoming paragraph on page 36.

[41] It should be noted that Denzin also discusses disguised observation in an earlier work in 1968, but I did not engage in any disguised participant observation.

obtained in the field. In addition, I was also able to triangulate information with an Ewe woman who lived and worked in the children's home I stayed in if I needed to visit Accra.[42] The home was a sister organisation of the NGO and the woman was someone who was originally from Abladzo village. She would return to the village from time to time to visit. She spoke both English and Ewe fluently.

The triangulation technique was employed to cross-check aspects of the women's interview data as well as my impressions from participant observation. Although this was done in mainly an informal manner, I have included the discussion with an Ewe elder about the idea that women in the village face coercive sexual experiences and even rape. The male elder confirms that this is in fact a part of a generalised social reality for many women in the village and not simply the personal experience of an exceptional unlucky few. Of course it should also be clearly understood that the circumstances of sexual inequality described in this thesis do not apply to *all* marriages or sexual unions in Abladzo and its surrounding villages. The idea that self-induced abortion was performed by many local women was stated by the women I interviewed who explained that 'most' women in the village area perform unsafe abortions and that self-induced abortions are 'common'. These statements are included in the ethnographic findings sections of the thesis and correspond with information gained from my experiences of participant observation in the local area.

I was very fortunate from an ethical point of view that while I wished to interview the women, there was an international volunteer at the clinic who was a trained nurse. In particular, she specialised in sexual health issues such as abortion and sexually transmitted infections and she was a qualified rape counsellor. While having the volunteer present at the interviews constituted another person with whom the women had to share information about their private lives, I felt that she could also be a supportive presence for the women and an ethical check for me. The participants were told of her professional skills and asked if they consented to the international

[42] Such visits were necessary from time to time due to circumstances such as illness, to fulfil visa obligations or to accompany international volunteers who were arriving or leaving Ghana. This was done at the request of the clinic director in order to assist him when he was busy with other obligations and unable to accompany the volunteers himself. Often one requires assistance with luggage and directions when travelling on local transport and I would accompany a volunteer and return to the village the following day. However, during my stay in Accra I would also take the opportunity to speak with the Ewe woman in the children's house.

volunteer also being present at the interview. They all agreed. The participants were also told that if they wished to talk to the volunteer at any time before, during or after the interview, they were most welcome to do so. The volunteer signed a confidentiality form agreeing not to disclose anything that the women said to anyone for any reason. The participants were informed about this agreement prior to the interview. I cannot be certain of exactly how the presence of the international volunteer impacted on my interview process. However, I did not detect any negative effects. Moreover, one participant did choose to avail herself of the international volunteer's professional skills at the end of the interview asking personal health questions to the volunteer directly and accepting the volunteer's offer of a medical examination about the problem concerned. These events are included in the third section of the findings of the thesis.

The participants themselves agreed to take part in the research after having the project explained to them by the clinic director a day or two before they agreed to the interview. Some participants were illiterate and although others had varying degrees of literacy. I was told that most of the participants would be unable to adequately read a research information sheet and consent document so it was necessary to provide an explanation of the research verbally. One of the participants was adequately literate so she was given a consent form to sign. The other participants gave their consent verbally on a recording device prior to the commencement of the interview. The interview questions were semi-structured and each interview took approximately one to one and a half hours.[43] In total six women were interviewed about their personal experience of self-induced abortion. This may not appear to be a large number of participants upon which to base the research. However, Abladzo and its surrounding villages contain only a small population of approximately 700 people so these six women do represent an adequate sample group of women of reproductive age for a qualitative study.[44] In addition, in justifying the small group of participants the fact that this subject matter is so personal should be taken into consideration. It can be

[43] See appendix #5 for the list of questions from the semi-structured interviews with women who performed self-induced abortions.

[44] It should be noted that of course just under half of these are men and many are women beyond reproductive years or children. In addition, the permission I obtained from the University of Canterbury Human Ethics Committee did not include minors or school-aged young women who according to research by Bleek & Asante-Darko (1986) are a population sub-group who potentially perform unsafe abortions. Thus I did not speak to any school-aged young people about my research.

very difficult for women to talk formally about self-induced abortion in Africa as much of the literature about this subject attests (Bleek 1981, p.208, Bleek & Asante-Darko 1986, p.335, Rasch 2000, Ahiadeke 2001, p.98). There are often negative social consequences for woman who are discovered to have induced abortion. Therefore, in order to protect the confidentiality of the women, the interview was done at a time and location of their choosing. Five of the six women chose to visit the clinic to do the interview, although one woman invited us to her home in the village where we sat outside near her house. Any contact with the women before or after the interview was done by the director of the clinic, rather than myself. With regard to social appearances, the director, as a local, would have a legitimate and ordinary social reason to visit the women which I would not.

In addition to the participants described above, four other local people were interviewed. The four participants who were interviewed were all literate and after being informed about the research, these participants agreed to the interview process and signed consent forms. The time and location of these interviews were again the participants' choice. These participants chose to speak in outside locations near their own homes and places of work. The interviews were again semi-structured except in the case of one participant who did not wish to be interviewed and preferred to simply talk about the subject matter. I felt that this was fine, if it was his preference. All the interviews were recorded with the participants knowledge and the recordings were transferred to a programme on my personal computer which was password protected.

These people were chosen for their knowledge of local history and traditional law. They were elders in the community and were recommended to me by the clinic trainees because of their reputation as good, reliable people with knowledge about such matters. In particular, one was a very keen historian of the local Ewe traditions and events. His knowledge was very broad and he narrated information to me freely. This was a particularly valuable experience as I had made significant efforts to find books containing this historical information, but failed. I had looked in a mission library in Accra as well as the city's public library. I had also searched a central library at the University of Legon but found most information relating to Akan peoples and little about Ewe. On returning to the village, I was told by local Ewe that

this was largely for political reasons and that most of the significant books about the local Ewe history and traditions were held in private possession.

I was very grateful for the depth of information that the local people shared with me. I do, however, believe that the use of the qualitative research methods did much to enable me to obtain much deeper insight into the social circumstances of unsafe abortion in the village area. This view is supported by Rasch et al (2000) who support qualitative methods of data collection with regard to research on abortion. They argue that qualitative methods are most successful because they can provide an empathetic environment for the participants to share their experience. The efficacy of qualitative methods is also perhaps proven by the research experience of a medical student who was doing a quantitative study about birth control in the village area while I was undertaking my fieldwork. In undertaking a yes/no questionnaire with local men and women, the student was told nothing about practices of unsafe abortion despite these being very central to the practice of local birth control. This research outcome is confirmed by Bleek et al (1986, p.335) who state that sexuality and birth control are 'such delicate issues and cannot be approached by close-end questionnaire interviews'. Despite being undertaken in an ethnic Akan Ghanaian community, a highly significant strength of an article about unsafe abortion by Hill et al (2009) is the social context provided to the reader due to the use of qualitative research methods. The study was able to access much more information about the social circumstances, motivations and methods of abortion used by women because of the choice to employ an analysis of women's abortion narratives as data. Although the key findings in Hill et al (2009) differed from the findings in this thesis, the efficacy of qualitative methods of data collection is difficult to deny.[45]

The participants in my research received 10 Ghana Cedis [$NZ 7.00] for the interview. I wanted to offer the participants something to thank them for the time and information they had given me. The issue of whether to offer money to the participants was something I had considered and discussed with my academic

[45] Seddon (1972) points out that social anthropologists are perhaps better qualified to explore the relationships between demographics, culture and society because they have longer, more intimate relationships with the people they study and have more intimate knowledge about birth, death and sexuality among these people.

supervisor before I went to Ghana. I understood that this may raise questions of 'inducements'. However, I chose to offer the participants money because they are very poor people and they need it. I did not feel at all comfortable taking information from the participants and giving them nothing in return. In addition, I asked the clinic director if my offering a gratuity would be seen culturally as an inducement. He told me that the people would simply be very happy and would not feel coerced. He also added that he was sure they would not tell me anything they did not wish to share, regardless of the gratuity. I therefore accept concerns about inducement as a rational critique of my methods but I do not believe that this was the 'lived experience' of the interviews. Ultimately, as I had time to progress through literature relating to questions of ethical engagement with subaltern persons and groups, I have come to understand that my need to offer a financial gratuity to the participants was also a personal attempt to address the inequalities present in my encounter with them. Of course, this money did not resolve either the inequalities or my discomfort but the work of Patai (1991) has helped me understand more critically my own decisions regarding ethical standards of relating to the people who agreed to participate in my research (Anderson & Jack 1991).

In particular Patai (1991, p.139) questions the use of very personal disclosures from which the researcher then attempts to focus the research as an occasion for advocacy but little real progress is made in terms of transforming inequalities. This is a fact of which I am only too aware. I was very particular in my interviews to ensure that the women understood that I was not a doctor but a student and therefore someone of very limited power in practical terms. I made no promises to be able to change anything but I did express my sincere desire for change for the women. I cannot say that these women held no hope of change coming from their interactions with me but they told me that it was God whom they saw as the source of any good outcome, not from me. Patai (1991, p.147) also critiques the use of advocacy as a sort of 'surrogate feel good measure' a 'means to console oneself about the real imbalances in power'. However, in dealing with this subject matter I believe I have made quite a shift in facing these inequalities. Previously my work has been focused on ethnographies which contain 'positive outcomes' for indigenous social actors. I referred above to being inspired by this kind of focus. I now accept that in large part this was a means to console myself about power imbalances, both my own and of the world at large.

However, these ethnographic accounts from the village did not allow me such consolation and because of that I feel that I have surrendered a little privilege in the sense that I now have this reality as part of my life experience which I cannot ignore or forget. Hearing the women's accounts and being able to do nothing is not empowering but humbling. My desire for well-being for these women is sincere, regardless of the fact of self-interest which, in varying degrees, is a component in all research (Patai 1991, p.139). Patai (1991, p.145) argues that 'ethics is not a matter of abstractly correct behaviour, but of relations between people'. In this matter I am confident that the relationships between the participants and researcher were as ethical as they could be in an unequal world.

Chapter Four
Literature and Analytical Framework

Noteworthy is the fact that there is very little academic literature in English available about Ewe people and culture. Studies of Ghanaian people and culture largely tend to focus on the ethnic majority Akan tribe and their language, Twi. While there are accounts of the Ewe, such as a very comprehensive study on kinship and marriage by Nukunya (1969), many of these concern Anlo-Ewe people and have limited value for this study because other tribes of Ewe have their own cultural and linguistic forms and expressions and differ too greatly with regard to the subject material of this thesis, to be generalised under a broad 'Ewe' umbrella. Moreover, much of the academic literature about the Ewe is not very current. Exemplified above is Nukunya (1969). In addition, there is a study specifically about Ewe cremation ceremonies by Ametewee & Christensen, which was published in 1977. While this work discusses aspects of the beliefs of Ewe people, including claims about abortion, the participants in my contemporary study disagree with many points of culture and ideology which Ametewee & Christensen (1977) have designated as belonging to the Ewe people. This could reflect inaccuracies or presumptions made by Ametewee & Christensen (1977), or may simply reflect the passage of time and the inevitable cultural and linguistic variations which have occurred in various Ewe groups over the three decades since the study was done.

The most comprehensive contribution to the academic literature of the English-speaking world about the tribe of Ewe in this study was written by A. B. Elis (1890). Unfortunately, his *The Ewe-Speaking Peoples of the Slave Coast* is a colonial work based on then-contemporary travel literature and his 'cultural' accounts seem to focus on intricate details of horrific rituals of human sacrifice and violence. This work is now considered to be highly deficient in facts and has been largely dismissed by Ewe. The book has also been dismissed by German scholars who completed studies of the Ewe during the German occupation of Togoland from which modern-day 'Eweland' was divided. Regretfully, this budding anthropologist is not literate in German so this body of literature was inaccessible at this time. Because of the paucity of accurate literature about the Ewe tribe in this study, the thesis relies heavily on oral history and

explanations given by people in and around the village of Abladzo. Post-fieldwork claims in academic literature were rigorously checked with contacts in the village in an attempt to ensure the highest degree of accuracy possible.

With regard to specific studies on abortion in Ghana, again the current literature has largely been of limited value to this study. The first reason for this is because like much of the other social research done in Ghana, studies have largely been undertaken in Akan communities and although useful for very general comparison, the data gathered does not relate to the cultural beliefs and social practices of the Ewe. It therefore cannot be relied on for any substantial critical contribution (Bleek 1976, Geelhoed 2002, Hill et al 2009). Likewise, the work of Anarfi (1996) is a composite of studies undertaken predominately in the 1970s and generalises the data found as being Ghanaian despite the differences in beliefs and practices of the various ethnic groups which constitute the nation of Ghana. More contemporary research done on unsafe abortion in Ghana has also been completed by Ahiadeke (2001). This study is based on a quantitative study methodology which was then compared to hospital derived statistics from national-based survey research. Although very statistically detailed, the work does concede its limitations by stating that 'women participating in community-based surveys on sensitive topics such as abortion are likely to underreport or may be unwilling to provide information' (Adiadeke 2001, p.98). Ahiadeke's (2001) work therefore provides a recent record of rates and ratios of abortion statistics for Ghana as a whole as well as the methods used by women, but provides no real depth of insight into the complex social world of self-induced abortion. In a more general sense, wherever possible I have also analysed comparative literature about abortion. It was at times fruitful to utilise academic material from studies of family planning and gynaecology which relate to other African, and in particular West African nations, in order to explain and support findings about the local Ewe women's use of public health services, sexual relations and contraception, for example (Cook & Maine 1987, Dixon-Mueller 1989; Coeytaux 1990; Hessini, Brookman Amissah & Crane 2006).

Coercion forms a key part of sexual social relations leading to unwanted pregnancies and subsequent unsafe abortions in the village in this study. Most of the studies about unsafe abortion or unwanted pregnancy in Ghana do not mention coercion or violence

as a factor associated with unwanted pregnancies (Bleek 1976, Ampofo 1994, Anarfi 1996, Adiadeke 2001 Geelhoed 2002). Surprisingly, even a most recent study by Kodzi et al (2012) entitled '*To Have or Not to Have Another Child: Life Cycle, Health and Cost Considerations of Ghanaian Women'* provides no specific details about patterns of coercive or violent sexual relations which limit women's reproductive self-determination and contribute to additional pregnancies. The study is an examination of rural women's personal reasons for fertility decisions; in particular, the choice to stop or limit childbearing. Kodzi et al (2012, p.967) argue that 'husbands tend to want more children than their wives and exercise influence and power in childbearing decisions in a major way'. Also that 'the mechanisms through which husbands specifically influence their wives fertility are not clearly documented, but it is known that husbands are more pronatalist' (Kodzi 2012, p.968). The study was undertaken in Akan and Ga ethnic communities, not amongst Ewe. Kodzi et al (2012, p.967) cite their study's uniqueness in adding a 'wide-range of personal-level factors' about women, to the data on fertility in Sub-Saharan Africa. Yet despite generally noting the imbalance of power in fertility decisions, they do not address coercive sexual relations or violence which leads to unwanted pregnancies. It is surprising that in a longitudinal study of women in six Ghanaian communities, between 1998 and 2003, Kodzi et al (2012) could not themselves document the mechanisms through which husbands specifically influence their wives' fertility. I argue this because of a study by Glover et al (2003) which found considerable degrees of coercion in patterns of sexual relations among Ghanaian youth.

The study by Glover et al (2003) entitled *'Sexual Health Experiences of Adolescents in Three Ghanaian Towns'* was focused on adolescent sexual health experiences and the sample groups for the study were, as the title suggests, taken among unmarried adolescents from three Ghanaian towns. None of the towns were Ewe. However, as in Kodzi et al (2012), the sample groups in Glover et al (2003) were ethnic Akan. Glover et al (2003, p.37) report data showing that 'women are often coerced or forced into sexual activity and that both sexes tend to accept violence towards women'. While the study was not focused on abortion, Glover et al (2003, p.32) claim that '70% of women in the study who had experienced a pregnancy had, or had attempted an abortion'. Also undertaken among an Akan population is a study by Bleek et al (1986) entitled *'Illegal Abortion in Southern Ghana: Motives, Methods and Consequences'*.

In part of this article, Bleek et al (1986) briefly discuss coercive relationships between female students and their teachers, which lead to the young women performing unsafe abortions. However, this part of the article focuses mainly on the fact that such events occur but does not provide analysis.

Despite the paucity of literature about coercion and violence as factors which create unwanted pregnancies in Ghana, there is a study by Ezeh (1993) which provides evidence of the prevalence of coercion against women among married couples in Ghana. The study is entitled *'The Influence of Spouses over each Other's Contraceptive Attitudes in Ghana'*. While the study does not discuss abortion, it does examine the fact that husbands exert considerable control over their wives' fertility and that their authority in such matters is considered legitimate. Forms of coercion used against the women in the study included threat of divorce and expulsion from the marital home, deception, and verbal abuse. Data for Ezeh's (1993) study is taken from qualitative evidence found in the Ghana Demographic and Health Survey and qualitative information taken from focus group research in Ghana. The data is relevant to this thesis because it demonstrates that spousal influence over contraceptive decision-making is a right exercised exclusively by the husband in many Ghanaian marriages. The right to sexual intercourse and control over many aspects of a woman's life, including control over her reproductive capacity, is described by participants in the study as belonging to the husband by the dictates of tradition (Ezeh 1993, p.171-172).

The second reason for the relevance of Ezeh's (1993) work is that the study includes focus group discussions from four different geographic and ethnic groups in Ghana. One of these is the town of Hliha, also known as Ho-Hliha which is in an Ewe district located in the Volta Region. I have not been overly reliant on Ezeh's (1993) study to inform my own work because the tribe under analysis in his work differs from the tribe in my study. However, I have used material about Ewe in Ezeh's (1993) study to support my own findings in a general sense where appropriate. The idea that coercion and involuntary sexual relations are associated with unsafe abortion is central to this thesis; and as detailed in the previous paragraphs, there is a significant lack of data in the literature about coercive and involuntary sexual relations which lead to unwanted

pregnancy in Ghana. It is my hope that data contained in this thesis will contribute to addressing that gap and to explaining the incidence of unsafe abortion.

Despite being an academic analysis from the perspective of the discipline of social anthropology, this research also very much concerns biological health issues, so in order to conceptualise and adequately explain the circumstances and events around the social practice of unsafe abortion in the rural village in Ghana, it was necessary to 'rethink the body' and conceptualise it in multiple ways. The thesis is broadly structured around Scheper-Hughes & Lock's (1987, p.6) concept of three perspectives from which the body may be viewed: as a phenomenally experienced individual body-self; as a social body, a way of thinking about relationships among nature, society and culture; and as a body politic, an artefact of social and political control. Scheper-Hughes & Lock (1987) use this perspective of three ways to view the body as a method of grouping the various social science viewpoints and contributions to the literature on the body and embodiment. Their article '*The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology'* is not a review but rather an overview of social science perspectives and an attempt to introduce the study of emotions as a new way to conceptualise studies of the body. I have used their idea of analysing the body from the three perspectives described above, as it provides a very clear overall framework upon which I can base my own work. The idea that the body and experiences of embodiment differ in individual, social and political perspective and experience, but that all three levels operate simultaneously on the body is fundamental to this thesis.

Accordingly, the practice of self-induced abortion is analysed firstly at the level of the individual body. Particularly for a western reader, this is perhaps the most self-evident perspective of the body. Scheper-Hughes & Lock (1987, p.7) explain that at this level the body is to be understood in the phenomenological sense of the 'lived experience of the body-self'. The perspective of the individual body self is largely based on the assumption that all social actors carry some intuitive sense of an embodied self which exists apart from other individual bodies. This theoretical idea of the 'individual body-self' is used to explore women's perspective on self-induced abortion as an act which allows them ontological security from the physical demands placed on woman in rural West Africa. Some local women see performing an abortion as a relief or

safeguard for their individual bodies, which they feel cannot always simultaneously cope with pregnancy and the physical demands of their agrarian life.

The analysis of the practice of self-induced abortion lends itself also to a discussion of the way in which a woman's body is not only an individual body-self but must be understood as a social body – a body belonging to sets of relationships with society and a culture. Scheper-Hughes & Lock's (1987) concept of the social body follows the trail of social, symbolic and structuralist anthropologists who have demonstrated the way in which the body becomes an interface for meanings created between 'nature' and society. In the village of Abladzo, the social and economic practices associated with farming are a central link between the society to which the women belong; and the natural environment. Abladzo is a self-sustaining agricultural community and for almost all the villagers farming is the primary means of livelihood. An analysis of the relations of production in the village area revealed the way in which women's reproductive capacity is an integral aspect of the economic mode of production. Despite the somewhat 'uneasy relationship' between Marxist theory and Anthropology, it is to Marx that I have turned in order to provide a theoretical framework to demonstrate the way in which the mode of production in Abladzo contributes to unwanted pregnancies and subsequent unsafe abortions (Firth 1975, p.43). Marxist theory has been accepted, rejected, interpreted and reinterpreted in a myriad of ways by Soviet Anthropology, American Anthropology and British and French schools of anthropological thought (Bloch 1983). Therefore, with the exception of an initial explanatory overview of Marx's theoretical intent, the following review of Marxist literature and theoretical concepts is necessarily restricted to selected key themes of interactions between Anthropology and Marxist theory as they relate to the most relevant issues of this analysis of unsafe abortion in the rural Ewe village.

I first wish to draw attention to the broad scope of Marx's theoretical and political ambition. He audaciously sought to demonstrate that capitalism, as the economic system of his day, was the product of particular historical circumstances. Marx wished to challenge the claim of capitalism to be the only possible natural economic system for civilised man. His highly political work required that he demonstrate the general forces which governed the history of man and the way in which 'historical processes

produce systems of institutions and ideas' (Bloch 1983, p.3). The notion that human history goes through certain ordered stages and that each stage has a corresponding economic epoch with 'social relations of production which correspond to the particular stage of development of their material productive forces' was fundamental to Marx's theory. It became known as Historical Materialism (Jacubowski 1976, p.30). For Marx, these stages represented a kind of evolutionism with societies moving inevitably through each of five stages towards capitalism. Marx also wished to demonstrate the dynamic change of each historical epoch; a change he saw as the inevitable result of conflict between the forces of production of a society and its relations of production. He saw these tensions or 'contradictions', as the downfall of all previous stages of social history and thus he believed they would also be the inevitable downfall of capitalism. Marx believed that the failure of a capitalist mode of production would lead to a socialist society and a subsequently superior economic and social system. My own theoretical ambitions are far more humble, and the movement of stages of human history is beyond the scope of this thesis. However, incorporated into Marx's theoretical work are notions of subsistence and labour as well as ideas about the forces and relations of production, which I wish to apply to my own study in the village of Abladzo.

In contrast to other theorists of his day, Marx saw reality as sensuous human praxis and he genuinely sought to link practice with theory. He regarded human beings as a social product but believed nature to be the basis for humanity's presence in the world and thus the fundamental aspect of social existence. For Marx, 'nature and man form a unity' (Jacubowski 1976, p.27). However, man is distinguished from animals by his production of the means of subsistence and labour which are necessary to him. Thus 'man's production of the means of subsistence is…a particular expression of his mode of life'. What individuals are coincides with production…and depends on the material conditions determining their production' (Jacubowski 1976, p.27). So for Marx, on the foundation of the forces of production, which include the conditions of nature, emerge the social relations of production (Jacubowski 1976, p.33). In every society there can be distinguished the forces of production and the relations of production. These are known in combination as the *infrastructure* of the society. According to Marx, this infrastructure is the economic base. In addition, the historical production of systems of institutions and ideas within a given society, Marx called the

superstructure. The superstructure 'generally consists of the legal and political institutions of a society as well as ways of thinking, ideologies and philosophies' (Aron 1968, p.121). I have employed these Marxist concepts of infrastructure and superstructure to an analysis of the way in which the mode of production in the village of Abladzo places many women under culturally and economically defined fertility patterns, which can be difficult to resist. Although it should be noted that exact definitions of what may constitute infrastructure and superstructure has, like many aspects of Marxist theory, been the subject of continued debate (Aron 1968, p.125).

It should also be noted that anthropological use of Marx's historical materialism should not be deterministic and regard the economic as overly constitutive of the social. Firth (1975, p.47) argues that 'sophisticated Marxist interpretations reject the crude determinism in the relation of the social to the economic'. On this point the work of Bloch is instructive. Bloch's book '*Marxism and Anthropology*' is largely an overview of multiple works by Marx and their historical relationship to the ideas and theoretical implications of anthropology (Bloch 1983). Bloch (1983) argues that Marx rejected the theories of his time, termed idealism, which saw institutions and ideas as the source of history as though these could exist in a separate state from the natural processes of human production and reproduction. He states that in Marxist theory we must see ideas as the results of people who are engaged in processes with nature. We should see the production of ideas as an 'aspect of the general enterprise of making a living from nature (Bloch 1983, p.27). Bloch (1983) stresses that Marx and his colleague Engels' rejection of idealism 'is qualified in that they also reject the crude materialism of [German philosopher and anthropologist] Feuerbach' (Bloch 1983, p.27). Even if nature is seen as the basis of human history, human society and concepts are not just an automatic product or reflection of a physical existence. Bloch (1983, p.27) refers to this misperception as 'vulgar materialism'. It is a position also rejected by Jacubowski (1976). Rather, it is important that we see Marx and Engel's theory as 'something of a balancing act between idealism and vulgar materialism' according to Bloch (1983, p.27). He argues that 'ideas and concepts… are not the reflection of the economic system but the product of a complex historical process of changing adaptation' (Bloch 1983, p.28). The key factor here is the idea that people's concepts, which are integrated into their way of life and their subjective experience,

are derived from man's interaction with the conditions of nature. However, it is also from history [perhaps intergenerational, for example] that ideas, beliefs and values are created in the first place (Bloch 1983, p.27). Ideas are an historical product of the need to organise society in order for people to be able to produce and reproduce. Thus, ideas which are ultimately based in material conditions of life have a history which is a complicated interplay and conflict of different factors, some material and some mental (Bloch 1983, p.29). Marx refers to this interplay as 'dialectical' and saw the interplay and conflict as the driving force of human history as a whole. This idea of interplay and indeed of emerging conflict between the infrastructure or economic base and the superstructure – beliefs, laws, philosophies or ideologies of Ewe society in Abladzo is central to understanding key aspects of why some women in the village perform unsafe abortions. I have attempted to demonstrate, using ethnographic examples relating to both the infrastructure and superstructure, a 'fit' between praxis and ideological gender concerns. I have attempted also to demonstrate the interplay and conflict which result in unsafe abortions. I wish to stress that I am suggesting a case for 'fit' rather than causality in a deterministic sense. A more comprehensive study specifically analysing the historical transformations in the mode of production and a deeper understanding of the superstructure, I believe would be required to demonstrate causality.

There is a complicating issue which needs clarification with regard to using a Marxist theoretical approach in this work. As described in the section entitled 'Abladzo a profile of the village', most of the local people are engaged in subsistence farming on communal land. I saw only one example, and indeed only once, of the use of mechanisation in the fields although some of the village cassava processing equipment is mechanical. The fact that many people are engaged in subsistence agriculture on communal land could perhaps place them in Marx's theoretical category of pre-capitalist people. There are also local people who have established larger, more productive farms, still on communal land, who subsist from these farms but also sell any excess produce at the local market or at the larger markets in Accra, Ghana's capital city. Some local farmers with large farms are able to export to markets in neighbouring West African countries although it should be noted that the economic yields from these activities are still very low. However, unlike a capitalist mode of production, the relations of production in Abladzo are not of an exclusively

economic nature. However, the fact that the relations of production are of an exclusively economic nature was a foundational aspect of Marx's theory in *Capital*. This fact became a significant point of anthropological critique of Marxist theory. In particular, it was led by French Anthropologists Godelier (1975), Terray (1975), Rey (1975) and Meillassoux (1972). The issue with Marx's theory was that his earlier work on pre-capitalist societies was unfortunately not very scientifically or historically accurate. Marx's earlier writings were largely based on the work of one early American anthropologist, Morgan. The tribal societies chosen by Marx in these works were selected, in the main, because they represented key attributes which Marx could use to contrast and prove his developing theoretical and political views about capitalism. The pre-capitalist peoples and social and economic forms provided the opposite end of Marx's evolutionary schema from the capitalist societies. The works such as *Forman* were an attempt to understand what institutions and social relations would be like when not moulded by capitalism, they were not an attempt to accurately analyse the social and economic circumstances of pre-industrial societies in and of themselves.

Marx made fundamentally wrong assumptions about pre-industrial societies such as the idea that because they were communal societies, they were also classless and devoid of exploitation. Such notions must again be seen in the context of Marx's desire to develop a theory of capitalism as well as a reflection of the limited number of studies of such societies and the Eurocentric scholarship of the day. Of course modern anthropologists refuted Marx's evolutionary sequence and many aspects of his ideas about communal social and economic realities. However, this left anthropology in a kind of theoretical 'limbo' with regard to Marx's work. On the one hand, his theoretical formulations of pre-industrial peoples were problematic for anthropologists because they were highly inaccurate but, on the other hand, later Marxist theories of capitalism concerning the ownership of private property and the means of production, and the idea of economic class divisions, did not provide an easy match to explain property relations or relations of production within the societies that anthropologists studied. Yet Marx's method for analysing economic and social relations in *Capital* was theoretically sound. Such a theoretical dilemma led Firth (1985, p.4) to state that 'Marx's theories anthropologically have no special claim to be historical or scientific, however, as a model, a series of systematically articulated

prepositions…they deserve continued scrutiny'. Regarding Marxist theory Bloch (1983, p.44) states, 'that such diverse aspects of society such as religion, kinship, politics and economics form a linked whole has been one of the touchstones of modern anthropology'. Similarly, Firth (1985) affirms the intellectual sympathies which exist between Marxist theoretical formulations and anthropology. He argues that 'anthropologists share with Marx the realisation that in an economy the relations between material things are really an expression of social relations between people (Firth 1985, p.34).

Clearly, Marxist theory holds general relevance in an anthropological sense. Thus despite the seeming disparities between Marx's theories and modern anthropological understanding, anthropologists persisted with Marxist interpretations. Of particular relevance to this study are the efforts of a number of French anthropologists who made attempts to revise aspects of Marxist theory in order to provide a framework which could more adequately explain African societies. There are two central aspects of this revision which relate directly to my analysis of the mode of production in Abladzo village. The first concerns the concept of the relations of production in pre-industrial societies. The work of French anthropologist J. Suret-Canale, advanced the idea of what became known as the 'African Mode of Production' (Bloch 1983, p.149). This had the effect of liberating French anthropologists from the Marxist formula of five stages of production in historical epochs, and opened the way for more particularistic interpretations of the infrastructure of pre-industrial societies although the analysis maintained Marxist ideas about 'structural causality' from his later work *Capital* (Bloch 1983, p.149).

A key aspect of the revision of the idea of modes of production was the fact that unlike capitalist societies, the infrastructure of pre-industrial societies was most frequently based on kinship relations. Thus, as described previously, the relations of production were not of an exclusively economic nature. A mode of production which depended on communal property, kinship labour and lineage familial organisation became known as the 'Lineage Mode of Production' (Bloch 1983, p.158). M. Godelier's (1985) work, '*Modes of Production, Kinship and Demographic Structures*' is an attempt to demonstrate why within a given society, kinship relations function as part of the organisation of production and, in a Marxist sense, the necessity to include

in the analysis an examination of the social conditions of production, the material means of social existence. Godelier (1985, p.4) argues in some societies kinship relations take on directly from within the function of the relations of production and that if this is the case, it is difficult to theoretically contrast economy and kinship as if they were two institutions with differing functions. Similarly, Meillassoux (1972) also argues against the Marxist notion of infrastructure and superstructure with regard to the social formulation of pre-capitalist societies. He claims that kinship alone provides both productive base and ideology.

However, I have retained the use of the Marxist concepts of infrastructure and superstructure. As discussed previously, the two concepts were never intended to show any sharp delineation between the forces and relations of production and the systems of institutions and ideas in a given society. Rather these should be seen as an interplay or interrelated within a whole, and never as institutions with differing functions in a concrete sense. With regard to Meillassoux's (1972) claim that the political economy is ultimately kinship anyway, I wish to maintain the Marxist concepts because they do provide clarity on the aspects of society which pertain to economic issues more strongly and those which pertain to ideas and philosophies. In particular, I have kept the concept of superstructure because almost all of the ideology or philosophies presented to me by participants did not refer to concepts of kinship directly but more to general ideas of gender ideology and cultural concepts of the 'Ewe man' and the 'Ewe woman' in a broad sense. I accept that this distinction is a fine theoretical line but I believe the idea of superstructure is suitable for the ethnographic material in this study.

Similarly, the work of Meillassoux (1972) uses the concept of a lineage mode of production to emphasise the importance of understanding the complex functions that kinship performs if it forms the relations of production in a society. In his article '*From Reproduction to Production: A Marxist Approach to Economic Anthropology'* Meillassoux (1972) explains the way in which kinship forms a productive and cohesive central base as well as an ideology. He aimed to show the way in which analysis should focus not on the historical succession of modes of production (as in earlier Marxist theoretical work on pre-industrial societies) but on the inner workings of societies in an analysis of the type which Marx made in *Capital*. Meillassoux's

(1972) analysis of the centrality of kinship in the economic and social organisation of a society stresses the importance of personalised social bonds in self-sustaining agricultural communities and, in particular, the importance of reproduction. He claims that 'concern for reproduction becomes paramount. Not only reproduction of subsistence but also reproduction of the productive unit itself' (Meillassoux 1972, p.101). This reproduction of the unit is biologically and structurally assured through control of women as 'the physiological agent of production of the producer' (Meillassoux 1972, p.100). The village of Abladzo depends almost entirely on kinship units as the relations of production. It is therefore important that considerations of the nature of kinship relations and their functioning as the relations of production are seen as a central factor in understanding patterns of reproduction in Abldzo and correspondingly the reasons for unsafe abortion.

In a theoretical sense the concept of a 'Lineage Mode of Production' is now viewed as being of only limited value as it led to 'a proliferation of modes of production' (MacGaffey 1985, Freund 1985, Geschiere 1985). Although the idea of multiple modes of production allowed for the emergence of concepts such as 'articulation' between different historical modes, such as pre-capitalist and capitalist overall, labelling a whole range of societies as manifesting the 'Lineage Mode of Production' makes it difficult to explain variations between them (Bloch 1983, p.159). Furthermore, if one focused on explaining the variations, the theoretical model became weakened. Geschiere (1985, p.83) stresses this point in his analysis of the theoretical concept of a lineage mode of production. He claims that in attempting to apply the concept in various fieldwork settings he could 'see the contours of the 'lineage' mode but that each society exhibited its own deviations from the general model. He also states how familiar Africanist anthropologists are with the way in which the 'rich diversity of African societies has a tendency to subvert neat analytical constructs'(Geschiere 1985, p.83, Hammond-Tooke 1984). He goes on to give examples of the variations he discovered in societies which made it impossible for him to apply a 'Lineage Mode of Production' theoretical model in any robust way. Thus, I have depended on the idea of kinship forming a central aspect of the infrastructure in Abladzo but I have not referred to the relations of production as a 'Lineage Mode of Production'.

In accordance with Geschiere's (1985) findings, I also discovered that it is extraordinarily difficult to 'apply neat analytical categories' to an African society; a fact which created additional theoretical considerations in this thesis. While I refer to kinship as being central to the relations of production in the village of Abladzo, I have limited my analysis of kinship relations of production to a focus on the household or family as the basic unit of kinship infrastructure. The reason for this is that the sheer complexity of patterns of kinship and the role kinship plays in social production and reproduction in African societies can be very difficult for an outsider to understand with any degree of accuracy. An article by Hammond-Tooke (1984) *'In Search of the Lineage*' highlights the complex level of social analysis required to write with anthropological certainty about African kinship structures and their social functions. He describes the 'elusive nature of lineages' and the detailed analysis of distribution of clan or cluster members which is needed by the anthropologist in order to demonstrate kin genealogical fealty and / or political fealty (Hammond-Tooke 1984, p.86). This is necessary so that the anthropologist can subsequently demonstrate the extent to which genealogically defined groups act as a common unit.

This level of analysis was beyond the limits of my research given that I had six months in Abladzo and it was my first encounter with the Ewe people. Thus, I am unable to demonstrate wider kinship structures as they relate to the agricultural mode of production, such as agnatic male cooperation in the labour process or collaboration between households. However, I believe that my focus on kinship relations of production largely within the household unit is appropriate in this research. Hammond-Tooke (1984, p.88) argues that 'as far as social reproduction is concerned, often the homestead [household unit] is by far the most important unit…' Certainly with regard to unsafe abortions, the immediate impact of the kinship relations of production is probably of greatest significance at the level of the household unit. Although the depth and complexity of the wider kinship relations are therefore inaccessible to the reader, the analysis of the basic household unit is still very effective in demonstrating the way in which a woman's reproductive capacity is

central to the relations of production in the local area and how this can in some cases contribute to unwanted pregnancies and unsafe abortions.[46]

Returning to the Marxist theoretical revisions, the second revision made by the French anthropologists was the inclusion of class divisions and relations of exploitation within the societies of pre-industrial peoples. This was a key link between using Marx's later theoretical formulations in *Capital* and being able to apply the framework to the tribal societies studied by anthropologists. The leading light in this development was P.P. Rey (1971, 1975, 1977) who reintroduced the Marxist concept of contradiction as being of central significance to Marxist anthropology. He established the notion of contradiction between both the development of the forces of production and the interests of different classes. Rey (1975) argues that class is a concept for all societies. In particular he stresses that elders in an African society could be seen analytically as a class in relation to various members of the community or, and of significance to this study, women can be seen as a class in relation to men (Bloch, 1983, p.160). He argues also that exploitation, as defined by Marx, takes place in social formulations where kinship exists as the basis of the relations of production. Rey (1975), Godelier (1985), Terray (1974) and Meillassoux (1972) successfully extended back from capitalist systems to pre-capitalist societies, the kind of analysis Marx had used. Recognition that this required the introduction of class as an analytical concept for the pre-capitalist societies was a significant element in this theoretical advance (Bloch 1983, p.160). There was however critique of the use of men and women as opposing classes and some anthropologists do not find it acceptable. They argue that men and women probably stand in such a relation in all societies and that a 'class' of women as opposed to a 'class' of men must be seen as different to the proletariat in an industrialised nation (Bloch 1983, p.162).

However, the demonstration of why it is theoretically reasonable to talk about a class of women in the same terms was provided by Terray (1974) in his article '*Class and Class Consciousness in the Abron Kingdom of Guyaman'*. Terray (1974) based his argument on Marx's distinction between 'classes for themselves' and 'classes in themselves' (Terray 1974, p.97). He defined the latter as groups standing in an

[46] These wider kinship relations may, or indeed may not be significant with regard to the issue of unsafe abortion in Abladzo village.

unequal relation to other similar groups in regards to the control of the means of production. Thus, in traditional African societies, age and sex groups are clearly 'classes in themselves'. Terray (1974) also argues that because the groups are primarily defined by biology it makes it more difficult for the exploited classes to become conscious of their condition as a class or to become 'classes for themselves' like those of a capitalist society. Bloch (1983, p.164) supports the analytical concept of men and women as classes stating that 'Terray's use of the Marxist notion of class, the key to Marxist social theory, does apply to the pre-capitalist societies and indeed reveals with great exactness their character'. I have thus relied on the concept of women as forming a 'class in themselves' in my analysis of social relations and the relations of production in the village of Abladzo. I have turned to the work of Terray (1974), also undertaken in West Africa, to assist my demonstration of the way in which women are exploited within the relations of production. Terray's (1974) work provides a powerful explanation of how conflict between men and women in relations of production, which rely heavily on kinship, can more commonly remain suppressed or will result in shorter-term resolutions. The social practice of unsafe abortion can certainly be seen as a short-term solution to gender conflict in Abladzo.

This thesis is also profoundly influenced by Turner's (1984) *The Body and Society*. His theory follows the work of Mead (1949) arguing that although it is tempting to accept sexuality as something simply 'natural', it is largely a product of very particular cultural considerations. His work is particularly relevant to this research because he offers a theory of the way in which an order of human sexuality corresponds to an order of patriarchy, property and production. Turner (1984) incorporates concepts of Marxist ontology and concepts from Engel's work *The Origin* to demonstrate how the treatment of sex is an integral part of the wider political and economic considerations of a given society. My decision to use Marxist theory in the earlier chapters about the mode of production in the village was, in part, to enable the reader to gain a broader neo-Marxist viewpoint within which the relevance of Turner's (1984) work could be contextualised. A more specific analysis of sexual social relations has been possible because of the application of Turner's (1984) ideas about the body and sexuality. Turner's (1984) theory focuses on the embodiment of social actors and the subsequent application of that embodiment to a functional social order, social control and system of social surveillance. For Turner

(1984), society would fail to exist without the constant and regular reproduction of bodies and without their allocation to social places. Of importance also is Turner's (1984) claim that the significance of Marxist ontology for the sociology and anthropology of gender has not yet been fully appreciated. As described previously, I have attempted to use Marxist ontological ideas to demonstrate the existence of exploitative patterns of fertility experienced by some women in the village of Abladzo, but I have also used Turner's (1984) theory to more specifically show the ways in which socially-prescribed women's roles in Ewe society correspond to the demands of the relations of production and combine to create an order of sexuality in the Ewe culture studied. This order of sexuality in a society is termed the 'mode of desire' by Turner (1984) and has physical, mythical-religious, discursive and ideological dimensions; all of which structure Ewe social relations and influence a woman's role in Ewe society.

A major consideration in this anthropological analysis of self-induced abortion as a social practice is the relationship between social structure and individual agency. A challenge of the thesis has been to demonstrate the relationship between the demands or structure of the patriarchal culture to which the women of Abladzo belong, and the degree to which they have choices or possibilities for exercising agency. The work of Ortner (1990) provides theoretical support for the Marxist analysis of discursive and ideological aspects of the local Ewe culture which are presented in two myths. The traditional stories concern cultural expectations of gender and they detail the prescribed qualities and behaviour appropriate to both male and female social actors. Ortner's (1990) theory offers a model of a cultural schema, defined as representation of a hegemonic selection of social practices put into a narrative shape in cultural stories, myths, legends and histories…(p.63). For Ortner (1990) cultures contain not just bundles of symbols or ideologies but the schema for enacting culturally typical relations and situations (p.60).

The Ewe stories of the people in this research offer insight into a cultural ideology which is built into the social superstructure outlining patterns of gender relations in the village. This ideology positions women as subordinate to men. The myth told is the creation of the first man and woman on earth and their survival together by obtaining food which has been placed on a wall. The hierarchical patterns of gender

relations outlined in the creation myth are commonly enacted by social actors in the village. While Ortner (1990) believes that culture defines the categories through which people experience and act on their world, she also strongly refutes earlier theoretical notions of cultural determinism or what she calls a 'programming view' of culture. Moreover, neither does she accept theoretical positions which claim that culture is a kind of 'symbolic ecology' of free choices. For Ortner (1990), the cultural schemas do form a symbolic ecology, but it is nonetheless a weighted ecology, not a realm of free choices. The use of the myths serves two purposes. The first is to demonstrate that an ideology of masculine superiority exists within the superstructure of Ewe culture. The second is to show the way in which the ideology functions to designate a cultural space to women both psychologically and physically. Of course in view of this paragraph, the inclusion of the Ewe myths is not intended to portray an overly-deterministic view of the impact of these stories on individual lives, rather it is intended that their inclusion contributes to building a picture for the reader of the complexity and embeddedness of some of the elements of the patriarchal cultural structure within which women negotiate their daily lives and enact decisions. The decision to induce abortion is not taken lightly by village women as it is strictly forbidden by local Ewe culture and is acknowledged as a very dangerous practice.

There are therefore significant tensions between the structure of the local Ewe culture and the degree of choice and agency desired and, when deemed necessary, exercised by the female participants in this study. In order to demonstrate the strength of the structuring components of Ewe culture as it is currently practiced in the village area, and a woman's choices within it, Giddens' (1984) *Structuration Theory* has been combined with Turner (1984) and integrated into an analysis of Ewe customary law relating to the expression of sexual social relations in the region. This section of the thesis describes traditional marriage relations and the way in which marriage ensures that the female body becomes inscribed with social sexual obligations which frequently reduce a woman's sense of autonomy over her individual body and can lead to unwanted pregnancies. In addition, currently the expression of sexual social relations in the traditional sense via marriage is undergoing a transformation. This transformation of the 'mode of desire' from being expressed within a customary marriage with the appropriate rights and exchanges taking place, to sexual unions

without marriage, has manifold implications for the lives of village women and does not improve either their social or sexual security. Indeed, despite changes in the forms of sexual interactions within the local Ewe society, the deeper systemic traditional ideologies associated with gender power relations remain. Therefore, although the outward forms of social practice are labelled as 'non-traditional' the structuring components which increase a woman's likelihood of unwanted pregnancy are ever-present and the options a woman has for exercising agency may be largely limited to a clandestine self-induced abortion if she does not wish to give birth to a child. The performance of an unsafe abortion is for these women, a courageous form of agency.

Giddens' (1984) theory is particularly relevant because his aim in establishing this theoretical position was to bring down the empires of structuralism and functionalism which strongly emphasise the social whole over its constituent actors. Giddens' structuration theory shows how concepts of action and meaning can relate to notions of structure and restraint. For Giddens the goal was not to emphasise the experience of the individual actor, nor the existence of any form of societal totality but social practices ordered across time and space. He argues that human action occurs as a durée – a continuous flow of conduct, as does cognition, and that in and through their activities agents reproduce the conditions that make the activities possible. The local Ewe customary law exists as social praxis ordered across time and space. The fact that such a thing as Ewe law is present as reality is because social actors produce and reproduce it through their actions and activities.

Giddens' (1984) theory also discusses the relationship between agency and power. He defines an agent as 'being able to deploy a range of powers including influencing those deployed by others' (Giddens 1984, p.16). The ethnographic accounts in this thesis describe the ways in which some local women deploy strategies to resist pregnancy, or in a broader sense and in following with the title of this work, the way the women resist reproduction. Giddens' (1984) work is useful because it informs us that even in circumstances of restraint where individuals 'have no choice' it does not mean the dissolution of action as such. This is a fact clearly illustrated by the ethnographic accounts given by the village women. Giddens (1984, p.16) argues that 'restraints do not operate like forces of nature' and that social scientists should not 'conceive of the structures of domination built into social institutions grinding out

docile bodies who behave like automata'. He shows that even codified laws are subject to contestation. Actors possess what Giddens (1984, p.3) terms 'knowledgability' or familiarity and knowledge of the social form and function of everyday life; and 'reflexivity,' which is a capacity to be both self-conscious and to monitor an overall ongoing flow of social life and thus produce and reproduce social structure. However, through Giddens'(1984) explanation of social actors' capacity for agency, it can be seen that individuals are also likely to perpetrate action in order to influence events. Therefore, despite an awareness of the social rules present in the consciousness of social actors, and conduct which accordingly produces and reproduces the structural properties of the larger collective society, this should not presuppose complete social cohesion. This is clearly demonstrated by the fact that some women in the village strictly adhere to local Ewe customary laws regarding pregnancy and believe that 'the number of babies God puts inside them is the number that should be completely out [delivered]'; while the participants in this research, actively contest such beliefs.[47] They seek to deploy power to change their circumstances and to subvert village elders' authority by aborting unwanted pregnancies. This analysis of the interplay between structure and individual agency provides answers to bio-medical literature which seeks reasons for women's 'unmet need for contraception' and women's seeming insistence on performing unsafe abortions despite contemporary family planning regimes.

The third section of this thesis is written from Scheper-Hughes' & Lock's (1987) perspective of the body politic – the body as an artefact of social and political control. In the spirit of critical medical anthropology, I have adopted and slightly adapted Scheper-Hughes' and Lock's (1987, p.26) idea that 'cultures are disciplines that provide scripts for the individual body in conformity to the needs of the political order'. Ghanaian national elites offer village women a bodily script concerning reproductive health which conforms to the health ideals of the contemporary global political order. However, the elite human-rights based discourse and its programs of action largely fail to meet the needs of many who live in Abladzo. The undeniable role that Ghana's place in the global political economy plays in the state's limited ability to provide adequate health care services for rural social actors is only part of

[47] Phrase uttered during personal communication with village women.

the reason for this failure. Of equal importance is the way in which global political interactions, international policy output and elite discourse impact on and shape Ghanaian policy output and programmes of action taken at the national level to reduce incidences of unsafe abortion. With respect to the concept of the body as a political artefact, the analysis of the international political discourses and policy output about reproductive health and gender equality reveals ideologies and discourses which, although inscribed on women's bodies via their integration into national health policy, in fact conflict with traditional social attitudes, discourse and praxis more deeply embedded in the everyday lived experience of local social actors. The result of this dual discourse as it relates to the practice of unsafe abortion is that despite commitments to international guidelines of best practice and the liberalisation of abortion law, incidences of unsafe abortion have not declined to any great degree in Ghana and remain especially high in rural Ghanaian villages such as Abladzo (Ahiadeke 2001).

The policy that the Ghanaian state has taken with regard to unsafe abortion largely follows international policy guidelines and development goals and, in particular, the Millennium Development Goal number 5 which concerns the improvement of maternal health. The practical outcomes of the policy uptake have been predominately bio-medical and technical solutions in order to improve state provision of reproductive health services. However, an article by Avotri & Walters (2001) argues that the women in their study did not see a lack of technical medical assistance or service as being a barrier to health, rather they emphasised social and material aspects of life. Avotri and Walters (2001) article is a response to what they see as literature and research about the health of women in developing countries which reflects the concerns of policy makers, healthcare professionals and experts but fails to represent the voices of women in the developing world. They argue that when women are 'given a voice' a different set of issues emerges. Notably, the study by Avotri & Walters (2001) was also undertaken in the Volta Region of Ghana among Ewe. Although the article does not discuss self-induced abortion, it provides a very thorough picture of the social and marital lives of Ewe women. Specifically, the two main themes that the Ewe women cite as being responsible for their health problems are their workload and relationships with men. The women saw their health condition

as corresponding to their roles in production and social reproduction (Avotri & Walters 2001, p.199). The intention of the article is to demonstrate that these Ewe women believe that their social and in particular, marital circumstances relate directly to their experience of ill health because of the culturally-defined gender inequalities which they must negotiate. These ideas form a significant part of this thesis also.

The article by Avotri & Walters (2001) leads into key ideas of critical medical anthropologists Kleinman (1995), Scheper-Hughes & Lock (1987) and Scheper-Hughes (1993) who discuss the phenomenon of medicalisation of individuals and societies. They argue that illness somatization has become a dominant metaphor for expressing social complaints and that negative feelings or indeed social distress can be transformed by bio-medical treatment regimes into purely biological diseases rather than being seen as socially significant signs of wider social problems (Scheper-Hughes & Lock 1987, p.27). In '*The Mindful Body*' Scheper-Hughes & Lock (1987, p.27) also point out that much attention has been given to the idea of the 'medicalisation of life and its political and control functions within industrial societies, yet there has been little research done on the effects of medicalisation in areas of the world where the process is just beginning'. The social actors who live in and around Abladzo have only recently had access to bio-medical solutions to health problems. Unfortunately, currently some village women are treated with temporary pharmaceutical solutions for health dilemmas which are largely the physical effects of deeply entrenched patterns of gender inequality.

The idea of the medicalization of social inequality in this thesis takes its central theoretical lead from Scheper-Hughes (1993) *Death Without Weeping: The Violence of Everyday Life in Brazil*, a work on the folk illness of 'nervos'. Scheper-Hughes' (1993) work explores the way in which an experience of chronic hunger is appropriated by medicine and transformed into a biomedical disease concealing the social conditions which are at the root of the issue. These circumstances are what Scheper-Hughes (1993) phrases as the 'social relations of sickness'. Her work is a powerful critique of the way in which bio-medicine can indeed mask destructive social relations by maintaining a collective denial of the social origins of a 'health' problem (Scheper-Hughes 1993, p.169). She argues that an individualised discourse on sickness then serves to replace a more radical social discourse and the deeper

origins of pain are ignored. A key feature of Scheper-Hughes' (1993 p.213) argument is that physical manifestations of illness can be a passive form of protest against an established social order. This inadvertent 'refusal' can thus contain the elements necessary for critique and subsequent liberation. This work on self-induced abortion follows Scheper-Hughes' (1993) notions of the social relations of sickness and illness as a potential form of refusal or protest. Currently many of the women of Abladzo and its surrounding villages suffer from an extensive degree of gynaecological illness. It is highly possible that at least some of these problems are caused by the use of the highly toxic local plant substance used to abort multiple unintended pregnancies. Moreover, these pregnancies are frequently the product of an experience of unequal sexual social relations which may be involuntary, coercive and unprotected. The women in this study describe real feelings of powerlessness and despair with respect to sexual encounters. Unfortunately, the gynaecological problems suffered by some village women, as a wider social sign of the collective experience of sexual social distress, are currently being medicalised. Many local women meet the sexual expectations of the masculinist culture at the expense of their physical and psychological health. Simultaneously, medical discourses about 'family planning' and 'reproductive health' are officially offered in place of a much-needed critique of unequal gender relations in Ghana.

The thesis also examines the degree to which the development projects established by the NGO are empowering the local women as is stated in the project mission statements on website representations, and by the project organisers themselves. The empowerment and assistance of local women is of importance to the projects' directors and their sincere efforts should not be underestimated. In an analysis of the the efforts to assist local women who perform unsafe abortions development perspectives relating to gender interests have been examined. Accordingly, the work of Molyneux (1985) has gained currency in social science circles for its cogent categories of gender needs. Initially employed in her analysis of women's interests in relation to the state during and after the Nicaraguan Revolution of 1979, her delineation between concepts of women's Practical Gender Interests (PGI) and Strategic Gender Interests (SGI) is used in this thesis as an evaluative model to assess the impact of the activities of the NGO at Abladzo with regard to women's gender interests. For Molyneux (1985) Practical Gender Interests (PGI) refer to the concrete

conditions of women's positioning within the gender division of labour. The interests are usually formulated by the women themselves within these positions and are a response to an immediate perceived need. However PGI do not usually entail a strategic goal such as emancipation or gender equality. Moreover, PGIs do not in themselves challenge the prevailing forms of gender subordination despite arising directly from them (Molyneux 1985, p.233).

The second category is termed Strategic Gender Interests (SGI) and these are primarily 'derived from the analysis of women's subordination and the formulation of an alternative, more satisfactory set of arrangements to those which exist' (Molyneux 1985, p.233). SGI consist of a set of ethical and strategic objectives to overcome women's subordination. I argue here that the NGO currently is assisting and empowering the local women's PGI but is making little contribution to their SGI. Ghana KINDNESS must respect the boundaries of the regional Ewe customary law and social practice in order to maintain good social relations with the community of the village of Abladzo as well as surrounding communities, and also ensure community cooperation with other local projects of great benefit. Overt tactics to advance women's SGI may jeopardise relationships of trust between the NGO and local leadership. Thus, the women are offered more covert, medical solutions to their health problems. Although such solutions are highly unlikely to get to the root of the problem for local women in need, the medical assistance provided by the clinic is saving multiple individual lives, and thus serving PGI in a very powerful way.

The work of Sen (1999) directly addresses the issue of women's SGI in his book entitled *Development as Freedom*. For Sen (1999) development cannot be conceived of in terms of narrow concepts such as improvements in individual income or industrialisation; rather he sees development as the expansion of different types of human freedoms relating to the capacities of individuals to live a life they truly value (p.3). Similarly, Sen (1999) states that while technical progress or solutions can contribute to enhancing human freedoms there are other influences which must be attended to by global policy and programs of action. He argues that individual agency is ultimately central to overcoming deprivation and oppression in the pursuit of development, despite recognising that it is constrained by social arrangements and economic paradigms. Sen (1999) argues that development consists of removing

various types of 'unfreedoms'[sic] which social actors experience. He thus cites gender inequality as being a significant 'unfreedom'[sic] which needs to be addressed. Sen (1999) questions blind adherence to traditional ways of life which maintain poverty or premature morbidity and advocates the opinion that traditions which create negative outcomes or breach human rights standards must be open to discussion by all members of a community.

Tsey (2011) also argues against blind adherence to traditions which may be harmful to vulnerable members of the community. In his book, '*Re-thinking Development in Africa: An Oral History Approach From Botoku, Rural Ghana'* Tsey (2011), who is an Ewe by birth, addresses the issue of the relationship between human rights and traditional social practice. He demonstrates the ways in which the local rural Ewe people in his study successfully found creative ways to adapt and reform age-old customs previously believed to be unchangeable as local values, world views and material circumstances also changed (Tsey 2011, p.97). Although Tsey's (2011, p.97) book addresses development in a broad sense and does not speak specifically about unsafe abortion, his arguments include gender equality as an aspect of 'a better future' and hence the development of a community. In agreement with Sen (1999) he advocates 'respectful but critical public deliberation' about the place of tradition and its capacity to benefit individuals and communities or its ability to 'undermine the search for a better future'(Tsey 2011, p.97). He argues that tradition that is of benefit and serves to strengthen communities must be recognised and incorporated into strategies for development.

Questioning the place of aspects of traditional values is highly relevant to the issue of female subordination in matters of sexual social relations in and around the village of Abladzo, and thus to the incidences of unsafe abortion which occur. It pertains directly to matters of women's emancipation and thus greater empowerment. With regard to women's SGI, in accordance with Tsey (2011) I argue that rather than entering dichotomised discussions about the sacrifice or maintenance of traditional values, it may be more beneficial to emphasise and reinforce the humanistic values which already exist within local Ewe customary law and culture, yet are neglected or perhaps misinterpreted to the detriment of the lived experience of sexuality of some local women.

PART ONE – The Personal Body

Chapter Five

She Used Sticks…

It was a Friday and the Abladzo Community clinic was peaceful. Small goats were eating the tiny, singular yellow leaves that had fallen from the acacia trees which shaded areas of the clinic compound. The cook and the midwife were sitting on small wooden stools, husking maize. A band of young children had gathered under the trees and some of them were kicking a thread-bare football around the area next to the clinic kitchen. It was late afternoon and I had been talking with Stacey, one of the clinic trainees.

Stacey: *'We had a woman in the clinic last night….she used sticks'* [48]

Me: '*She used what?'*

Stacey *'You know…. sticks'* [looking directly at the table and avoiding my eyes]

It wasn't unusual for patients to come to the clinic at night but Stacey's tone was furtive and I wanted to understand.

Me: *'What do you mean, sticks?'*

Stacey: *Here in the villages people use like traditional medicine to abort the pregnancy, but if that thing goes wrong they come to the clinic for a help. And then some people they will help them to remove the sticks from their vagina because they use a stick to abort the pregnancy. Even some people they will grind a bottle…*

Me: *Oh…*

[48] Stacey uses the term 'sticks' but in fact the terms twigs or stems would convey a more accurate impression of the size of the plant material used.

Stacey: *...and put it in a local drink and drink it.*[49] *They will drink it to make the pregnancy got spoil.*

Me: *But that doesn't go to your vagina...it goes to...*

Stacey: *Yeah...but they don't know. Sometimes it doesn't work. Some people think that if they do that it will work but sometimes it doesn't work, they will just hurt themselves...*

Me: *Have you seen that at the clinic?*

Stacey*: Yeah, I seen that once in a certain girl who insert a medicine into the vagina to abort the pregnancy and according to her, she had the medicine for about three days and everything become worse and she came to the clinic but the pregnancy already aborted.*

Me: *Did she insert sticks?*

Stacey: *It was another kind of medicine but plenty people use sticks too.*

The violence involved in this practice on the body seemed incongruous with the peace and gentleness of my immediate physical environment at the clinic. However, this was not the first time I had heard of the village women inducing abortion. There had been references in passing in other stories of people or events, but this was the first really open declaration of the practice of self-induced abortion in Abladzo. I had been living there for over three months and I have to admit that my initial impressions of the clinic and the village were shallow. In those first three months, I was like the other international volunteers who came to the clinic, well-intentioned but quite devoid of any real appreciation of the depth of the struggle of everyday life in the village. Of course, in a Goffmanesque (1971) sense, performances of social life also mask social praxis which would be seen as too unpleasant or detrimental to the impressions of village life that locals wish to portray. To some extent then, being privileged to only a very gradual unfolding of local realities is both a matter of local pride and security as well as an ethnographic inevitability. However, even a little insight into community life reveals that the practice of inducing abortion is common in Abladzo and the

[49] The local drink Stacey is referring to is Akpetesi, a kind of local alcohol made from palm sap. It is similar to vodka but very, very sweet. It is reputed to be about 80% proof.

surrounding villages. Although there are several methods employed by the local women who perform abortions, the most frequent is the use of a plant known as *Babati Te* in the local Ewe language.[50]

***Babati Te* as an Abortifacient**

I had been invited to speak about the *Babati te* with a local woman whom I shall call Adjoa.[51] She was known to the clinic director as having induced an abortion relatively recently. She, like a considerable number of other local women, had run to the clinic late one night when she was unable to stop the bleeding.[52] She had sought help from the director of the clinic. Adjoa was a beautiful woman. She was 28 years old. Her face shone when she spoke and she seemed to exude a kind of amiable openness. She had invited me to interview her at her home in the village. Her house was typical of the homes in the village which are mostly constructed of mud brick with a thatch roof. We were greeted warmly and we sat outside the house to begin the interview. Adjoa had her two year old baby daughter on her knee. I was surprised that she seemed unconcerned that others may overhear the subject matter of the interview but after the initial curiosity of seeing *yevu* [white people] sitting outside their neighbour's house, the villagers just went about their business and I began my journey of trying to understand why many women in the local area perform unsafe abortions.[53] Adjoa explained how some local women use the *Babati te* plant to facilitate abortions:

Me: *So can you tell me how the women in this community, how do they actually do the abortion?*

[Adjoa laughs…]

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[50] The Latin name for this plant is ***Jathropha*** or ***Jahropa Curcas*.** It is also called ***Nkrangyedua*** in Twi. See Anarfi, John K. *The Role of Local Herbs in the Recent Fertility Decline in Ghana: Contraceptives or Abortifacients?* 1996. See also appendix #6 for a photograph of the plant.

[51] Adjoa is a pseudonym given to the woman in order to protect her privacy and maintain confidentiality with regard to her identity.

[52] The trainees working at the clinic had told me that it was common to see patients late at night who had attempted abortion.

[53] I was actually very concerned about other people overhearing the conversation and placing Adjoa at risk. However, the clinic director said because of his presence the people would simply think that he was visiting Adjoa to say 'hello' and that he had brought a *Yevu* [white person] from the clinic. I decided to trust that these locals knew better than I did about what or would or would not place Adjoa at risk.

Me: *Sorry….*

.

[Adjoa still laughing] W: *You are right to ask me and I am ready to answer.*

Me: *Ok, thank you*

A: *I have herbs that I dig from under the ground or sometimes I buy medication from the [herbal] pharmacy but only if I have money.*

Me: *Do you take it orally?*

A: *The one that I take from the pharmacy I take orally, but the one that I take from the bush, I insert into the vagina.*

Me: *Is it sticks? I have heard people talk about using sticks….*

A: *It is Babati. This tree…*

She pointed to large trees growing in a clump behind us in the village, only about 5 metres away. Adjoa then leaned forward on her chair and shouted to a child standing near the trees to bring some leaves over to us. The child complied and ran to Adjoa handing her two or three quite large, green leaves from the tree.

A: *We have the red one and the white one* [red Babati and white Babati plants].[54] *It is very dangerous. You put it in here* [gestured to vagina] *and then insert this [*stem*] into the cervix.*

Me: *How many stems? Lots? Just in case I get pregnant while I am here!*

[Adjoa was laughing] A: *Use only one because it is very strong. This one is too soft* [she looked dissatisfied as she picked up a stem of the Babati]… *and the one used*

[54] The red Babati is also a traditional medicine. However, it is the white Babati or *Babti Te* which is used as an abortifacient.

should be harder like this [she found a more suitable stem and pulled it open to show the viscus substance inside]. *If you cut it…you can rub that liquid around it. The liquid is a poison that opens the cervix.*[55]

Me: *How long do you need to keep it in there for?*

A: *When you insert it today…this morning…..by the evening then blood starts coming profusely but the process is that when you do it this way…after inserting it into your cervix, you have to tie a string and then tie it around your waist…otherwise the stem will penetrate into your cervix.*[56]

Me: *Does that happen to people?*

A: *Yes. If it goes in, it kills you.*

Me: *Oh, has that happened to people here?*

A: *Yes.*

The Role of the Abladzo Community Clinic

The project organisers of the non-governmental organisation Ghana KINDNESS which provides medical services at the Abladzo Community Clinic did not mention the practice of self-induced abortion before I arrived in Ghana, but I know it is a situation of great concern to them. The Director of Ghana KINDNESS and project founder for the Abladzo Community Clinic ensure that oxytocin injections are available to local women who attempt abortion and subsequently require medical assistance.[57] The clinic however does not offer abortion services. The clinic is praised by everyone in the local community. However, for many of the women of Abladzo it

[55] See appendix #7 and #8 for photographs of the stem and viscous substance of the plant which is used to abort a pregnancy.
[56] Other participants reported tying the string to the top of the thigh.
[57] Oxytocin is a pharmaceutical medicine used to stop the bleeding.

has a special significance. It offers real security from the risks of unsafe abortion. One participant explained:

W: *I came to the clinic last time only three or four days ago because I [had induced abortion and] was bleeding profusely.*

Me: *Were you afraid?*

W: *Yes, I was very scared that the blood wasn't going to stop. That's why I ran here [to the community clinic]. I was given Oxytocin.*

Me: *Ok. Do you believe the clinic has been useful for women in this area?*

W: *Yes*

Me: *In what ways?*

W*: It helps in so many ways. It helps other women too. Firstly, before it was someone who introduced me to the clinic…a girl who had the same problem…abortion. She said she was bleeding or she bleed and was rushed to the clinic and was given an injection and it stopped. So that compelled me to come and to rush here*.

Ontological Security and the Individual Body-Self

Despite the potentially fatal results, the use of *babti te* as an abortifacient was described by all the participants as an effective substance and a necessary way to achieve control over the body and thus their personal circumstances. In a paradoxical way the use of this very dangerous plant offers the women of Abladzo village greater ontological security (Giddens 1991). Giddens (1991, p.243) defines 'ontological security' as a feeling of security which is derived from 'a sense of continuity and order in events, including those not directly within the perceptual environment of the individual'. The avoidance of chaos is the cognitive and emotive anchor of feelings of ontological security (Giddens 1991). An unintended pregnancy may cause a woman to

lose a sense of continuity and order over her body and life and create unwanted physical hardship and associated emotional distress. This can be best understood initially by using Scheper-Hughes & Lock's (1987) concept of the personal body. It is a phenomenally-experienced individual body self or a 'lived-body'. There is little that can prepare the average western citizen for the experience of everyday life in Africa. Perhaps most striking is the sheer physicality of existence. This is particularly true of rural life. For any person, regardless of a place of birth, the body has a mandate over our everyday experience. Our corporeal existence is dominated by the need to eat, wash, groom, dress, work and sleep in so far as we are inescapably embodied (Turner 1984, p.1). However, for a woman in rural Africa, the demands of embodiment are considerable indeed. The women of Abladzo village rise at dawn and wash the family clothes by hand. They must also carry water and cook for the family before going to their respective farms to do heavy manual labour until the late afternoon. The evening is spent cooking. Some participants expressed concern about the physical difficulties associated with a pregnancy under these life conditions:

W: *The most important thing is that as a pregnant woman you need not* [should not] *go to farm to do any hard work but since you are in a rural area, you are compelled to go*.

Me: *Under all circumstances?*

W: *Yes, you must go to the farm and do manual work.*

Me: *…and so what happens to the women who do that?*

W: *Of course some never suffer anything but plenty bleed or suffer miscarriages.*

Me: *Ok, for some it is very, very hard then.*

W: *It is a problem to them because some people even after six months they become pregnant again but with the coming of the clinic it has given them a lot of education so they are trying to space their children so they can rest their body.*

Me: *Sometimes spacing means babati?*

W: *Yes.*

In her chapter about quality maternal healthcare and development Unnithan-Kumar (2008, p.404) states that for women in the developing world 'childbearing and birthing carries with it the potential of a very serious risk to one's life'. She cites the poverty-related nutritional deficiencies, difficulties in accessing water and sheer physical work that 'frame the contexts of the continuous biological reproduction' of the lives of women in the developing world (Unnithan-Kumar 2008, p.404). These factors make childbearing a 'physically debilitating and unsafe period' for rural poor women in particular (Unnithan-Kumar 2008, p.404). In addition to the heavy manual farming labour performed by the women of Abladzo village, the practice of headloading provides another example of the strain placed on a woman's body in rural Africa. Headloading is the practice of transporting goods by balancing them on the top of one's head.[58] It is common practice in much of Africa and equally so in rural Ghana. A large percentage of a rural woman's time is spent transporting goods in this way and often over considerable distances. They have few alternatives. The burden of transportation is gendered in Africa and falls largely on women (Porter 2008, Blackden & Wodon 2006, Okojte 1994).

Upon arriving at the Abladzo clinic in early September I was astounded to see the weight of the headloads carried by the people of the village. It was harvesting time for the cassava crop and the local men, women and children were transporting baskets of the heavy root vegetable on their heads. Many of the headloads carried by adults would easily weigh upwards of 40kgs. The maximum head carrying load recommended by the specialised labour agency of the United Nations, the International Labour Organisation (ILO) is 20kg (Malmberg-Calvo 1994). Moreover, during the six months I spent in and around the village area I saw women and children often carrying head loads of water or food staples from the local market. Sometimes it was very clear that such loads were far too heavy and the physical strain on the body of the carrier was obvious. In addition, I frequently observed women headloading

[58] See appendix #9.

very large baskets of goods and simultaneously carrying a small child or baby tied to their back in the traditional way. The local people are very proud of their strength and would often tease me about my undeniable physical inferiority.[59]

However, such a physically demanding life does inevitably become detrimental to one's health and this is particularly so during pregnancy. Excessive weight loaded onto the head leads to back problems as the weight causes strain on the skeleton of the carrier (Gruehl Kiphe 2009). I was told by the clinic director that over time headloading can cause the compression of the spine, knee problems, neck problems and headaches. Unsurprisingly, back pain was a common problem presented to healthcare workers at the Abladzo clinic. In addition to this, while accompanying a volunteer midwife to an outreach clinic in the local area I was surprised when a group of pregnant women asked me to give them packets of paracetamol. They explained their request by simply stating that their bodies 'hurt all the time from working too hard'. Despite being pregnant, it is often difficult for the local women to attain periods of extended physical rest as the participant described previously. Moreover, it takes a significant amount of energy to sustain such physical effort. Headloading thus makes serious demands on the metabolism which must be addressed by an adequate nutritional intake, although very often in rural Ghana these nutritional needs are not met. This is a particularly serious situation for pregnant women. The local women to whom I spoke were very aware of the dangers of being pregnant in such a physically demanding rural environment.[60] They understood that in particular, repeated pregnancies which are poorly spaced placed their bodies under terrible strain. This is one reason why some women turn to unsafe abortion in order to protect themselves from the potentially fatal risk of childbearing and birthing. The use of *Babati te* as an abortifacient provides women with a sure method of exercising control over their personal lived body. As described above, for some social actors an abortion is a means of spacing children and escaping an additional, unwanted and even dangerous physical strain on the body in an already highly physically demanding environment.

[59] Within the first three months of living in rural Ghana I had lost 6kgs. This was unfortunate as I only weighed 58 kgs before going to Ghana. I often felt physically exhausted from carrying heavy buckets of water in order to bathe twice daily or to wash my clothes by hand. In addition, I was required to bring food or other goods from the market. Of course the physical demands of my life were almost nothing compared to those of the local people.

[60] The idea of rural women desiring to limit their fertility in order to protect their personal health is cited also in Kodzi et al (2012).

This chapter has provided a phenomenological perspective of the social practice of abortion as seen through the personal body-self of women from Abladzo. They perform self-induced abortion at enormous risk with the use of the local *Babati te* plant. The constant, heavy work which rural women must undertake, places them under enormous physical strain during a pregnancy. Some women feel unable to meet these physical demands and prefer to abort an unwanted pregnancy in order to protect their own lives. This is said to be particularly so for women who have only recently given birth. The reality of embodiment however, never entails only the personal experience of a phenomenological body-self. The body is always simultaneously a social body. A body is subject to the multiple sets of relationships present in the wider society to which an individual belongs. It is from the perspective of the sociality of a woman's body and the influence of these social relationships that part two of this thesis further explores why some women in Abladzo turn to unsafe abortion.

PART TWO – The Social Body

Chapter Six

Family Planning vs The Economic Modes of Production and Desire

For Scheper-Hughes & Lock (1987, p.6) a social body is 'a natural symbol for thinking about relationships among nature, society and culture'. In order to truly understand the social practice of self-induced abortion, the body, and in particular the female body, must be seen as a kind of social interface which is integral to the production and reproduction of multiple kinds of relationships with other social actors but also among nature, society and Ewe culture. Contemporary efforts to encourage family planning as a method of reducing incidences of abortion in communities such as Abladzo cannot be successful by simply offering various medical solutions to individuals. Nor can shallow interpretations of cultural factors be of assistance if again the aim is to simply facilitate medical 'compliance' by individual body selves. For in so far as the female body is part of a society, it is deeply embedded in sets of social relationships and subject to social regulation. According to Giddens (1984) the very basic constitution of society presupposes a duality of structure and agency expressing as relations of both autonomy and dependency. While the women of the village can exercise autonomy or agency over an unwanted pregnancy by using the *babati te* plant, by virtue of their socially constructed gender identity, they may face serious social constraints in using family planning.

Me: *I also heard that a lot of the time the men in the community refuse to wear condoms. Is that true?*

W: *It's true.*

Me: *In that circumstance do women still have sex with them?*

W: *We cannot refuse because even if you show it [the condom] to them they will throw it away. They will not…they don't know the use of the condom. They don't want to know.*

Me: *Why not?*

W: *My husband, whom I am staying with presently now said he hasn't even seen a condom before and he doesn't even know how to wear it.*

Me: *Can you talk to him about it?*

W: *No, he yells at me*

Me: *What does he say?*

W: *There are some men who say they don't have the ability to use a condom. They say that whenever they use it…even for two hours they will not produce any sperm.*

Me: *They won't produce sperm if they use a condom?*

W: *They feel the skin is not touching….they feel that the skin is in the rubber and the skin is not touching the penis….because of that they have the idea that they will not produce any sperm. He yells and says that if you use a condom, then he will have no sexual desire…and he will not use it. He might even have sex with someone else. Even if he doesn't have sex with someone else, he will grab you by force and have sex with you.*

The example of the limits some Abladzo women faced using family planning were also described by this participant whom I have called Maria:

M: *Yes, the clinic has given some sort of power to women*

Me: *In what way?*

M: *Right now if you don't want to be pregnant early you can come here for an injection or for a pill and your husband will not know.*

Me: *Right. Is it important sometimes that the husband doesn't know?*

M: *There are some men who would never allow you to do family planning so you have to do it secretly.*

Me: *Why will they not allow that?*

M: *Sometimes your child will be very young…one and a half to two years and you, the woman, you might not feel like having a child but the man wants so many children to work for him in the farm. So he wants you to produce more.*

Academic literature cites spousal veto over family planning services as a serious threat to the lives of women and children (Cook & Maine 1987, Hord & Wolf 2004,). Yet all the participants in this study describe their spouses as being very opposed to the use of contraception.[61] The lack of control over sexual encounters and sexual reproduction that many of the local Ewe woman experience can in part, be seen as a direct product of the inter-linking of the local economic mode of production and patterns of sexual social relations. Anthropological research has demonstrated the way in which sexuality, which appears as simply 'natural,' is in fact the product of very specific cultural arrangements (Mead 1949). In the following chapters I wish to show how some local Abladzo women experience alienation from their bodies as socially constructed notions of sexuality merge with the demands of the local political economy. This merger engenders the sexual subordination of women as an everyday aspect of social praxis fundamental to the production and reproduction of social and economic life in the Ewe village.

[61] Spousal opposition to contraception is also cited in ethnographic examples from the Volta Region in Ezeh (1993, p.171). Ezeh's (1993) study also demonstrates how sexuality is very much culturally constructed, in accordance with Mead (1949).

The Local Economic Mode of Production

No one can escape the reality of the need to produce the means of existence from material conditions. Hence a woman's body is part of a social dimension in rural Ghana, as it is an integral aspect of producing the economic means of existence. A woman in the village of Abladzo is required not only to provide her body to labour as discussed in chapter three, but also to labour in the sense of the biological reproduction and birthing of human beings. Here Marx's theory is instructive. Marx argues that social beings transform and appropriate nature through a collective labour process. In a most basic sense human beings must transform the natural environment to survive. They must cultivate crops and domesticate animals thus producing the means of production which provide a livelihood. In accordance with Marxist theory, the economic base or infrastructure of a society is constituted, in part, by two sets of governing forces. The first of these are the forces of production. These are the physical means and techniques of production. They include the instruments of work as well as the skills, strengths and knowledge of producing agents. In the area of the village of Abladzo, the forces of production can be seen as the sun, rain, land and other natural elements required in the farming process.

The second governing force of Marx's infrastructure of a society is the relations of production. This is the set or sets of social relations through which productivity ensues. In his *'Preface to the Critique of Political Economy'* Marx states that ' in the social production of their life, people enter into particular necessary relations independently of their will, relations of production, which correspond to…their material productive forces' (Jacubowski 1976, p.30). For the people of Abladzo these relations of production are also kinship relations. The primary productive unit is a patriarchal household consisting of a husband and wife/wives and their children. For many of those born in and around the village of Abladzo the relations of production are very much entered into 'independently of their will' as they are born into farming families and their lives usually do correspond to the material forces of production available to them. Some of these families have very low or sometimes no level of literacy and therefore must produce their livelihood from their farms. Thus the conscious use of fertility can be a fundamental part of the infrastructure in the village of Abladzo and women's biological labour can become a key force of production.

The intensity with which some local men insisted that women reproduce was something that unsettled me while I lived at the clinic. What seemed to me to be an almost fierce emphasis on reproduction in Abladzo is discussed by Meillassoux (1972) in his analysis of a rural West African society. He states that self-sustaining agricultural communities in particular, stress the importance of reproduction. He claims that 'concern for reproduction becomes paramount. Not only reproduction of subsistence but also reproduction of the productive unit itself' (Meillassoux 1972, p.101). I often had time to talk with both local men and women who would walk through the compound on the way to their farms located behind the clinic. The local villagers would talk about how important it was that their crops were successful, or how they feared too much rain or indeed not enough at irregular times in the farming seasons. One old man told me quite specifically that he feared starvation every year. He told me he was tired of always being worried about the failure of his crops and not having enough food for himself and his family. The man also talked about the importance of having enough people to work the farm and ensure its productivity.

Concern for reproduction of a labour force is certainly a contributing element to the desire for large families in the village of Abladzo. I believe that one aspect of women's lack of control over their reproductive capacity is firmly anchored in social fears for food security. Many women are expected to follow cultural fertility patterns which, in turn, ensure large family units which can labour on the farms and produce food crops. In a Marxist sense, the relations of production in the village very much reflect the material conditions of existence from which productivity must ensue. The level of female sexual oppression associated with the relations of production can be explained in part by significant levels of poverty experienced by most local people in the district. The village of Abladzo is located on local Assembly maps as being among the poorest communities in the already impoverished district. Madut Jok (1999) demonstrates the connection between women's lack of control over reproduction and 'pronatalist' communities which are under severe social stress or where survival is threatened.[62] In the absence of other options for creating a livelihood, some of the local men of Abladzo strongly assert the use-value of a

[62] Jok (1999) discusses a Sudanese community and the impact of war on women's reproductive health. While the residents of Abladzo do not live in a conflict zone, there are similarities associated with the level of social deprivation such as food scarcity, illiteracy and limited access to medical assistance.

woman's reproductive capacity. Unfortunately, the impact on women's reproductive and psychological health goes largely unconsidered as childbearing is deemed a woman's fundamental cultural role. Therefore, gaining a local man's co-operation or acceptance of methods of contraception is very difficult indeed for some of the women of Abladzo village as many local people believe that their very survival depends on the birth of children.[63]

However, to limit the discussion to notions of survival or subsistence would not be very accurate. While subsistence food supply is most certainly a significant concern for many in the village, it is not the only contributing factor to unwanted pregnancy. In fact, the pursuit of wealth and status also play a considerable part in reproductive pressures placed on women. Many in the village would agree that the more individuals to labour on the farm, the better. Although land is communally distributed through the village chief, security and social status are gained from having a very large and productive farm. Sometimes local men prefer to marry multiple wives as it provides the very best possibilities for gaining a large labour force from their progeny.[64] Even men with only one wife will endeavour to maximise the wife's reproductive potentiality because it corresponds to security and wealth creating opportunities as described by Maria above. Yao, a 25 year old unmarried participant described this situation to me with some cynicism:

Y: *Yeah... some people will say i don't want a children [sic], but the man will not agree and because you don't want to divorce your husband* [65]

Me: *...So he'll divorce you if you say you don't want any more children?*

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[63] For a discussion of spousal veto over contraceptive use see Cook & Maine (1987, pp.339-344) or Ezeh (1993).

[64] Zeitzan (2008, p.150) argues that building up a large household is typical of those in West African cultivation societies. She states that additional wives have always been economic assets in West Africa because of the cost and difficulty in obtaining wage labour and she adds that plural marriages will probably continue in areas where the economic basis is cultivation rather than wage labour.

[65] The idea of divorce as a consequence of not following a husband's wishes is supported in an ethnographic example from the Volta Region in Ezeh (1993, p.172). The young woman states that '*some men think that women are common, so if it is not good for you, you can leave and they will find someone else*'. The social implications of this threat are made clear by another woman in Ezeh's (1993, p.170) study who claims that divorce is not an option because an Ewe woman will only face the same circumstances in the new environment and that '*'We [women] have to humble ourselves to them [men]. Even if you are right, you have to humble yourself by all means. Men are all the same'*.

Me: *Really, wow!*

Y: *Yeah...because some people [men] they need a children,[sic] that's why they marry. That's what most of the men target.*

Me: *They target women because they want to have children? Is it to have someone to help work on the farm?*

Y: *Yes. Yeah if some people we interview them they would say they want plenty people to work in their farm...to help them in their farm. That's why they marry two or three women...to give birth to plenty children so that they help them in the farm.*

Me: *Hmmmm*

Y: *Not to take them to school and all that...It's to help them on the farm.*

Me: *So it's economic?*

Y: *Yeah*.

This extract clearly demonstrates the link between the mode of economic production and the use of female reproductive capacity in the interests of advancing agricultural production. The reproductive capacity of women is incorporated into the relations of production and a woman may lose a significant degree of control over her body as it becomes a tool in the process of transforming nature into an economic or social product.

Again in a Marxist sense, social praxis and the relation of ways of thinking about circumstances and problems can be better understood as part of the process of history (Bloch 1983, p.27). It is here that we can begin to see more clearly the interplay between the infrastructure of the village of Abladzo and the superstructure or systems of institutions and ideas of the society. The concept of needing many children has been an inherent part of Ewe society in this area for many years. Here it is important

to demonstrate the way in which the superstructure or systems of institutions and ideas in the Ewe lineages of the area can materially disadvantage women through ideas about patrilineal descent and patriarchy. The idea that material security, particularly in older age, is gained by having many children is an advantage which can apply more to men. Despite giving birth to the children and being their primary caretaker in most ways, the child's obligation to provide material assistance upon maturity is first to the father. This is a contributing factor to some women's reluctance to divorce. An elder male in the local area stated :

B: *To be precise, in our traditional marriage females are suffering because in other tribes [in Ghana] the female must benefit from the children but in this tribe….in our region the woman does not benefit, the husband does…meanwhile the wife must do the greater part of the work.*

Me: What do you mean the woman does not benefit from the children?

B: After [in most cases limited] education and I am productive, I must help my father not my mother. In our tribe this is the case. It is patrilineal. In actual fact the woman suffers most…with the upkeeping of the child she gains less.

Another participant told me that:

W: *It is true that in the olden days lots of men in the villages gave birth to as many children as they can to enable them to have helping hands on their farms. Some also gave birth to many children with the intention that death is inevitable [and] for that matter they can never predict the future or the number [of children] that death will lay its icy hands on. I know a man who said he gave birth to 107 children to nine wives and he explained to me that in those days, giving birth to many children served as future security and a social prestige about one's wealth*.

Me: *Do those ideas still persist?*

W: *Yes, to some extent it persists…*

For Marx, the already existing ideas, practices and values of a given society are themselves the product of previous encounters and answers to the challenges of nature (Bloch 1983, p.27). The above extract demonstrates the relation between ideas and practical problems. Having many children was a way to ensure the continued production and reproduction of human beings in Ewe society. An excess of production was a form of wealth because it answered the real material problems of existence. These ideas are not simply 'the reflection of the economic system but the product of a complex historical process of adaptation' (Bloch 1983, p.28).[66] Currently in the village the idea and practice of having many children persists. This is largely because the dominant mode of production in the village and the same material life challenges have also persisted for many people. In some respects the reliance on self-sustaining farming has actually increased. The construction of the Aksombo dam in the Volta region has meant a decline in aquatic food supplies for those in the area. Moreover, deforestation has meant that additional food sources traditionally obtained from the bush are no longer available or are greatly reduced. Many local people lament the necessary reliance on cassava farming which they have come to accept within the last ninety years.[67] Colonisation increased commercial agricultural production in the region and privatised some local land. The nearby townships and the city of Accra demonstrate to a greater degree, a capitalist mode of production. Thus there exists a degree of articulation between a more capitalist economic mode of production at the margins of village life and the dominant pre-industrial mode of production which still forms the centre or base of the village existence. In this respect, the pressure on women to reproduce has not changed greatly because the acquisition of more land is dependent on communal allocation and is quite freely available in most cases. Therefore, security and the expansion of wealth, or the acquisition of prestige goods such as motor vehicles, is still determined for the people of Abladzo by how productive one's farm can be; and productivity as has been discussed, is dependent on women's bodies to supply a labour force. This is a significant reason why the transformation of women's circumstances is slow.

[66] I cannot do more than hint at these given the limits of this thesis.
[67] This time frame of 90 years was given by locals in personal communications at the village.

Women, Transformation and Class Conflict

Marxist theoretical perspectives are perhaps most well-known for ideas about societal transformation. Marx was particularly interested in the dynamic of what he called 'contradiction' between the relations of production and the forces of production. For Marx a certain mode of production is always combined with a certain mode of cooperation as a productive force (Jacubowski 1976, p.35). Clearly, the mode of production in the village of Abladzo is dependent on the reproductive cooperation of the local women. However, Marx also states that 'at a certain stage of the development of the material forces, the relations of production break down and classes which were previously cooperative 'begin to thrust against the limits of the old mode of production'(Jacubowski 1976, p.35). This 'contradiction' between the forces of production and the outlined mode of production manifests itself in…social struggle'(Jacubowski 1976, p.35). Some women in the village of Abladzo perform unsafe abortions in order to resist the current relations of production. This can certainly be seen as a form of social struggle.

As I have discussed in the literature section of this work, the idea of women forming an analytical class in opposition to men in a given society is something about which anthropologists cannot find consensus among themselves. However, I have adopted the theoretical position offered by Terray (1974) who argues that in African societies where the relations of production are based on kinship, women can be seen as forming a class and experiencing exploitation. Terray (1974) based his argument on Marx's distinction between 'classes for themselves' and 'classes in themselves' (Terray 1974, p.97). He defined the latter as groups standing in an unequal relation to other similar groups in regards to the control of the means of production. In these more traditional societies a division of labour exists and the recruitment to the group within the division is predetermined by differences in sex, age or kinship category. Thus, in traditional African societies age and sex groups are 'classes in themselves'. In the households of Abladzo, women stand in an unequal relation to men in regards to the control of the means of production. In so far as women are unable to control their reproductive capacity, they have unequal control of the means of production. For Terray (1974, p.95) and Rey (1971) exploitation exists when there are conditions of extortion. Terray (1974, p.95) defines this as ' the forced levy and appropriation of surplus labour by others regardless of the purpose to which the product of this surplus

labour is put…[even if] it be used for expanded reproduction of the mode of production of the non-producers…' In the village of Abladzo the labour or coerced biological reproduction of children, surplus to real need, is used by many men as non-producers of this labour in order to expand their farms and create wealth. Terray (1974, p.96) argues that 'even if the intensity and social effects of exploitation vary according to the use made of the extorted surplus labour, the fact of exploitation is itself independent of such use'. However, as will be demonstrated by subsequent chapters in this thesis, the intensity and social effects of the exploitation of some women's reproductive capacity is a very serious matter in the village area. Moreover, the absence of significant change in the conditions of exploitation over time can make it appear as 'an inescapable, natural phenomenon free from the vicissitudes of history and the action of man' (Terray 1974, p.98).

With regard to the idea of change in the conditions of exploitation experienced by some women in the village, Terray (1974) also makes a very significant distinction in his definition of the constitution of classes in pre-capitalist societies. In the face of this kind of exploitation of women, Terray's (1974) distinction may be particularly useful in assisting a reader to understand why unsafe abortion as a resistance to the current mode of production does not manifest itself as an overt class opposition or unified class conflict with a subsequent social transformation in patterns of relations. As noted in the previous paragraph, one factor is that the absence of significant change in the conditions of exploitation can serve to naturalise social circumstances making continuous pregnancy seem an inescapable fact of life. A second key factor is that in a more traditional society where household kinship relations operate as the relations of production, women, or whatever category of persons occupying a definite position in the kinship system, 'may be regarded analytically as a class, but all actual communities regardless of their scale are cross-cut by age and sex differences and include various categories of kin. The distinctions may be the basis for various kinds of groups, age sets or women's groups, but no autonomous community can be formed from these groups' (Terray 1974, p.96). Therefore often with regard to pre-industrialist societies 'as far as the sexes are concerned the physiological and economic division of labour creates such close bonds between them [the sexes] that neither could conceive of itself without the other, nor set its goal as the liquidation of each other'(Terray 1974, p.96). The necessity of the bonds between the sexes was

emphasised by women in the village who told me clearly that they did not wish to be left cultivating land without a husband or male partner. They stated that such an existence is a terrible hardship. For Terray (1974, p.96) disharmony may be legitimately seen as class conflict but the characteristics of the society as outlined above 'prevent women from becoming conscious of themselves as a class and thus collectively proposing the reorganisation of society on the basis of their class interests'. This collective reorganisation based on unified interests of the group is what Marx defines as 'a class for themselves'.

While I was living in the village area, I once remarked about the intensity of the workload the local women had to endure and the degree of tolerance some women had to show towards their husbands' demands. I asked if there was anything women could do collectively to complain about such life circumstances or to even protest. In particular, I wished to know if there were any traditional authorities to which women could petition. I was told that men could say and do almost anything except verbally insult a woman's genitalia.[68] This was something that was considered absolutely unacceptable because it was from a woman's sexual organs that a man possessed life. I asked what would happen if a man did such a thing and I was told the following:

M: *A man can insult women, beat them and make terrible demands and the woman will obey but if a man insults woman's sexual organs she will protest loudly….she will gather other women and the man will be chastised. He will be forced to walk through the village into the town and at each village more women will join the walk. All the women will beat him all the way to the town. They will beat him with their underwear. The man will be very afraid of this because the men believe that if they are beaten with a woman's underwear, they will get leprosy. When they reach the town, the man,*

[68] This apparent lack of recourse to social justice is not present in all rural societies in Ghana. Tsey (2011, p.89-91) describes traditional actions for justice for women in cases of violence or rape against them. These are patterns of social relations which the women in my research said they could not oppose. In contrast to Terray's (1974) ideas about women in pre-industrial societies not uniting as a class in order to bring about change for their own interests, the action taken by women in Tsey's (2011) research could very much be described as uniting as a class. However, the book does not describe fertility patterns in the town nor whether it would seem possible to the women to protest expectations of reproduction should they be unhappy with the status quo. Also Sefa Dei (1994, p.15) cites the presence of secret gender societies in Ghana and claims that these contributed to 'diffusing gender tensions' but among the matrilineal Akan people, not Ewe.

he will be tied and taken to the Queen Mother for judgement. Yeah the men are scared. They think they can catch leprosy this way….[women laugh loudly].[69]

This can certainly be seen as women uniting on the basis of their own interests. It also suggests that they are aware of themselves as a class. Furthermore, it illustrates at least some degree of traditional recognition of women's rights. However, I believe that this example of women's empowerment in the local area is acceptable predominantly because it is ritually enacted on a single unfortunate male and its impact is largely at an ideological level. Although it sets a limit to women's tolerance of the abuse of male social privilege, it has no real impact as a force of transformation of social order or patterns of gender relations in the village. In particular, the protest has no impact on the economic base of the society as a whole. It does not challenge the relations of production. If women were to unite as a class and address the issue of male demands on their reproductive capacity, it would certainly be seen as very threatening to economic survival and to men's capacity to accumulate wealth. It could in Terray's (1974) terms be seen as an attempt to 'liquidate each other'. Collaboration at the level of the household unit is seen as a very important aspect of social life. According to Terray (1974, p.96), in pre-industrial communities, the idea of mutual dependency causes class conflicts to 'remain fragmented and seldom forged to produce general confrontation at the level of the total community'. Thus female and male class contradictions present in the households of pre-capitalist Abladzo village cannot lead to a revolution or the overthrowing of one class by another in a Marxist sense and hence to a transformation of social relations in these ways (Terray 1974, p.97). Terray (1974, p.97) argues that only a development within the productive forces of such societies can result in the transformation of these contradictions or 'an outside intervention linked to the action of another mode of production'.

Of course for some of the women of Abladzo village this 'outside intervention' has come in the form of the contraceptive injections and the emergency use of oxytocin provided by Ghana KINDNESS NGO. Although the economic mode of production of this Ewe society places some women under considerable reproductive pressure, as

[69] In light of Douglas's (1984) work on categories of pollution and taboo, here it is interesting to note that when women's sexual organs are under male control they are seen as something productive but when women assert power with regard to limits over their sexual organs, their underwear, by symbolic extension is seen by men as a fearful and polluting force.

described previously by the participants in this research, these interventions have 'given more power to women' in the sense that they have made women more aware of the possibilities of a life without continuous pregnancies. The NGO intervention has served to de-naturalise notions of exploitative fertility patterns as an inescapable, ahistorical condition free from the actions of man. It is important to note these changes taking place in the village for the women because it is not my intention to portray Abladzo as a place locked in a kind of 'homeostasis' of tradition (Beattie 1966, p.59). In fact there are both positive and negative changes occurring and indeed changes which demand the reorganisation and re-evaluation of traditional social praxis and belief.[70] However, with regard to ideas and practices about women's reproduction, frequently more traditional attitudes certainly prevail and change is very difficult for some women who desire it. The village economic mode of production and the fertility expectations inherent in the relations of production are very important reasons why many women experience unwanted pregnancies and perform unsafe abortions.

[70] I am referring to the fact that more recently the chieftaincy of the neighbouring village has not been bestowed on the family decreed by tradition but, at the demand of the people, given to a family with strong local lineage connections who have sufficient wealth, education and social connections to the West to ensure more rapid development of the village. Many of those nominated were educated in the west and do not live in Ghana currently. The chieftaincy has been taken from those traditionally entitled because they are viewed as lacking the financial resources and education to advance the development needs of the village as a whole.

Chapter Seven

The Superstructure and Myth

The previous chapter was concluded with the idea that there is change occurring in the village and that some women are beginning to reject the idea that continuous pregnancy is simply a natural fact of life. However, the process of change is greatly challenged by local ideological traditions. For Marx, although the economy is the base of society and is central to understanding patterns of social relations, the elements of the superstructure of a society, such as the legal, philosophical and religious ideas or concepts of tradition are very much part of an interplay with the economic and also 'wield their influence upon the course of historical struggles'. Terray (1974, pp.98-99) states that tradition plays a dominant role in which patterns of social relations and a corresponding mode of production are based. Moreover, he states that that in societies with relations of production based on kinship, as in other societies, it is 'always in the interests of the ruling section of society to sanction the existing order as law and to…establish its limits given through…tradition'(1974, p.98). The strength of tradition is proportional to the permanence of social relations and does not necessarily 'prevent a dominated class from becoming conscious of itself but it at least leads it to doubt its capacity to transform a situation that appears to be the effect of the nature of things'(Terray 1974, p.99).

Marx distinguishes between two 'strands' of the superstructure although in reality the separation is methodological because they form interpenetrating or 'dialectical' aspects of a societal whole (Jacubowski 1976, p.39). However, in pursuit of clarity I have employed this distinction between the legal aspects of the superstructure, which will be addressed in the following chapter, and the philosophical and religious ideology addressed in this chapter in an examination of two traditional local myths. The myths demonstrate the way in which gender ideology, inherent in the superstructure of local culture as tradition, influences social praxis by defining the Ewe female as subordinate and obedient to the Ewe male. These forms of gender ideology may reinforce women's subordination to patriarchal values and thus influence women to at least doubt their capacity to truly transform these values which

appear as an undisputable social order that has stood the test of time (Aron 1968, p.158).

Bomenor and the First Man and Woman on Earth

As in chapter four, the idea of subsistence and women's subordination featured in my discussions with local people, but this time ideas about gender roles in the local area merged with ideas about subsistence and social praxis. Here we begin to see the interplay between the infrastructure and the superstructure of the Ewe society. Many local villagers had told me that Ewe people are patriarchal but I had asked a local man to explain to me why men were in charge and women were supposed to be obedient. I had heard the local men talk about the 'necessity' of women's obedience and women themselves talked with resignation about their obligation to be obedient to men.[71] The local man explained these gender expectations in the following way:

Ewes believe that human being is a stranger on earth and they stay for a while and then go back to the hometown. The hometown for human is called 'Bofe' or 'Bome' or 'Dzorfe'. Mother for everyone in Bome is 'Bomenor'. They have no father. Bomenor does not give birth but creates babies from dust or mud. Bomenor created a male and female as strangers on earth with flesh to be visible and to stay together.[72] Bomenor left them on earth and told them that she would call them if she needed them and then Bomenor returned to Bome forever. That is how human beings came to earth and how they depart the earth. So after Bomenor created man and woman and put them on earth, she wanted to know the one who will listen to the other. Bomenor put food on top of their fence wall and was watching them…

It came to a time when they were hungry and the woman asked the man to go and bring the food that is on the wall so that they can eat. The man refuse and after about two hours, the man asked the woman to go and bring the food that she was talking about. The woman went but her hands couldn't reach the food. She calls the man and asks him to lift her on his shoulder so that she can pick up the food. The man refuse and put up his hands saying that his hands will go and bring the food. When the man

[71] This obligation was often fulfilled in appearance only when possible for the local women.
[72] The Ewe belive that human beings are given flesh to make them visble on earth.

realise that his hands were not going to bring the food, he asked the woman to lift him on her shoulder so that he will bring the food. The woman agreed and the man took the food, give it to the woman and he gets down and they ate.

Since then, because it was the man who brought the food, he was in charge of bringing everything into the house or to the family and because the woman obeys the man she was obedient. Hence the man is in charge and the woman is obedient up till now.

This creation myth provides insight into the cultural ideology behind patterns of gender relations in the village. The myth offers a framework for the potential social subordination of women by making the first woman ever created obedient to the man. The woman tries to assert herself by requesting that the man bring the food. However, the man refuses. The myth thereby engenders the man with a 'natural' unwillingness to comply with the requests of the woman and implies by a kind of default his natural social role as the leader. The man then asks the woman to bring the food and she attempts to comply with his wishes again illustrating her implied proclivity to obedience. Despite her willingness the woman is portrayed as being physically inadequate by the phrase 'her hands couldn't reach the food'. Again her request for assistance from the man is denied by him. Thus she is disempowered again by his lack of co-operation and the myth reinforces the seeming impossibility of male following female in such matters. Interestingly the man is also portrayed as being physically unable to reach the food alone. This part of the myth fuses the man and woman together on earth in mutual need of one another. They must co-operate in order to eat, hence survive. Here we see an ideological aspect of the myth which conforms to Terray's (1974) ideas about the mutual dependency inherent in pre-capitalist societies. In particular, the way in which the sexes are concerned with the physiological and economic division of labour and the way in which it creates such close bonds between them that neither could conceive of itself without the other' (Terray 1974, p.96). The interplay or 'dialectical interaction' between the material needs of the infrastructure and ideological aspects of the superstructure can be seen as reciprocal spheres of the social whole. In the myth, the man again refuses to enable the woman but the woman is compliant to the man's wishes by lifting him on her shoulder to enable him to reach the food. She again supports and empowers the man at his request. In return for her

obedience she is given her share of the food by the man. In this way, the female gender identity is socially constructed as being dependent on the male for her survival but the myth also prescribes that her obedience to his will ensures the survival of both herself and the man. She must assist him and the ultimate attainment or achievement of goals will be only with him and in submission to him since, according to the myth, inherent gender characteristics of both the man and the woman naturalise the social order.

The story of Bomenor and the first Ewe man and woman caused me great confusion because I had been told by local people that Mawu [God] was in fact known also by the name Mawu Sogbolisa and was both male and female. I therefore could not understand how the Ewe people could have a god that was both male and female but still place ideological emphasis on the subordination of women. I asked the local man to explain this and he told me that:

Traditionally there are three Gods: Mawuga [God Almighty], Mawu Sogbla [Male God] and Mawu Sodza [Female God]. Mawu Sogobolisa is the collective name for both the male and female God. Mawu Sogbla is very powerful and punishing but Mawu Sodza is very kind and nurture, gives blessing and look after the life of people. There is believe in Ewe culture that men and women are the representatives of Mawu Sogbla and Sodza respectively on earth. The male god is superior over the female god and we [Ewe] attribute it to man and women on earth.

This is why in society of Ewe culture, women have no power to do anything but to stay in kitchen to cook, give birth and care for children. The superior [male] have to provide food, shelter, clothing, security and other essentials in Ewe culture.

Here again, the socio-religious prescription of gender is evinced in another version of the Ewe cultural ideology. This time the woman is attributed the personality qualities of the female god Mawu Sodza which makes her kind and disposed to looking after others. This kindness and helpfulness toward others can be seen as very similar indeed to the qualities of the first woman created by Bomenor who was very helpful by always assisting the man in the way that he requested, therefore looking after her own, but also his life. In addition, by attributing the male god with superiority in power and

making him punishing, the implied inferiority and obedience of women in the first creation myth is reinforced. The cultural ideology is important because it provides the ideological definitions of a socially-constructed female identity which, in turn, serves to produce and reproduce a culturally-defined female bodily praxis in complementary opposition to a socially-constructed male identity and corresponding bodily praxis. It can be argued that the philosophical and religious elements in the superstructure serve as cultural instruction regarding correct social gender forms and behavioural ideals. Anthropologist Ortner (1990, p.60) cites the influence of myth on social practice.[73] She states that 'every culture contains not just bundles of symbols or ideologies but also organised schemas for enacting culturally typical relations and situations'. She states that 'a cultural schema represents a hegemonic selection, ordering and freezing of a variety of social practices into a particular narrative shape by virtue of their representation in cultural stories, myths, legends and histories…' (Ortner 1990, p.63). According to Turner every society has rules for governing bodies. 'Their allocation in time and space and a legitimate body identity are powerful socially-constructed facts' (Turner 1984, p.1). The ideological characteristics of women and men provided by the Ewe myth serve to locate gendered bodies in social space. Within the constructs of the gendered ideology, women become allocated largely to the private realm in order to cook, give birth and care for children. The female is the embodiment of kindness, blessings, care for others, inferiority and obedience to male will.

In some circumstances these ideological gendered identities did emerge clearly in structured patterns of social practice. Cooking is an example. The task of preparing and serving food was certainly allocated to, and performed almost exclusively by women. However, men did not always fulfil these gendered social roles prescribed in the myths, or rather, they were selective about which aspects of the ideology they would emphasise. While I did meet men at the village who took their socially-prescribed masculine responsibilities very seriously and provided well for their families, this was certainly not the case with all men. Often the ideological attribute of superiority was embraced by local men in their cultural definitions of their gender

[73] Beattie (1964, p.24) also states that the anthropologist is interested in myth because 'myths…express current attitudes and values, perhaps in symbolic form'. Also that 'myths imply some sort of evaluation, some statement of the way in which the people who have the myth think about themselves, and about the world and what they consider important…myths tend to sustain some sort of system of authority'.

role, but their subsequent social responsibilities to the woman were neglected. Frequently many women had to do a great deal more in practice than stay in the kitchen and cook, give birth and care for children. In addition to the childcare and housework tasks, they would be required to work on the farm and to engage in petty trading of necessities such as soap or baked food. A woman would be obliged to increase such activities if her husband did not provide money for the family.[74] Ezeh (1993, p.172) describes the social change which has occurred in Ghana that sees a woman's role in the marital home nowadays as 'going beyond cooking to feed the household'. This means the woman is now also responsible for the economic means to accomplish her new role as the food provider. This seemed to be the circumstances of some women in Abladzo also. Some local women told me that very often the financial responsibility for the family can fall on the woman if the man chooses to neglect them.[75] In this respect, it becomes easy to understand why women would be afraid of increasing numbers of children under their care and some may resort to secret acts of self-induced abortion.

It also becomes clear that the definitions of the female and male in the Ewe myths may at least in part, facilitate the interests of patriarchal power structures. The ideology reinforces notions of male superiority, social authority and efficacy and recognises women's efforts and competencies only in relation to their service to others and in particular, subordination to men. According to Jacubowski (1976, p.55) ideologies do not emerge directly from the relations of production but are produced by human beings and as such they are 'the products of particular desires, impulses, interests and needs which, for their part, are biologically determined and then quantitatively and qualitatively structured by the socio-economic situation'. It is then not surprising that in the village of Abladzo a woman's worth is largely measured by

[74] Ezeh (1993, p.171) also provides ethnographic evidence for men in Ghana failing to fulfil their culturally prescribed gender obligations towards their wives. The elderly women in Ezeh's (1993) study say that they prefer the past because despite a wife's obligation to extreme subordination 'men played their roles [as provider] very well' but nowadays the women claim 'it is a problem for men to provide their quota…'. Although this particular example does not come from an Ewe community, I believe that the same transformations of gender role obligations are occurring in the Volta Region among the people of Abladzo. Ezeh (1993, p.171) also provides one ethnographic example from the Volta Region of a woman who states that her husband will not permit her to use family planning but adds 'worst of all he is not even prepared to look after me and the children'.

[75] Such conversations took place with the women interviewed for the research but also individuals who would come to the clinic to visit their friends the trainee healthcare workers or people who were waiting for others who were receiving treatment at the clinic.

her marriage and capacity to bear children. Moreover, many women in the area abide by this definition of their social role and measure their worth accordingly. By producing many children a woman is conforming to cultural notions of good womanhood. Pregnancy is very much expected and required by local men. It is a form of female cooperation but even more than this, it is simply an inherent part of being female. Thus, the women in this study who perform self-induced abortions are doing so against the enormous social pressures inherent in the patriarchal traditions of the superstructure of their society.

Marxist theory focuses on society as a whole and Marx did not concern himself much with the consciousness of the individual, but saw it largely as a product of the class of society to which he or she belonged. However, anthropology is interested in the agency of individuals. While Ortner (1990) argues for the philosophical or mythical elements of a society being part of a wider 'schema' in which cultural praxis exists, her theory was not intended to be overly deterministic. She clearly argues that social actors both manipulate their culture and are constrained by it. I also do not wish to present an argument which is overly deterministic. A central concern of this thesis is to demonstrate the degree to which the women of Abladzo village can and do manipulate their culture by performing abortions, and the degree to which culture and socio-economic environment constrains their agency. Of course, these factors vary somewhat from individual to individual. However, the participants in this study offered a remarkable degree of uniformity in their explanations of village life, despite their different ages, marital and social status. The social practice of self-induced abortion is therefore a weighted decision in which the local women exercise agency within a variety of cultural institutions which structure Ewe social life.

The purpose of this chapter was to show that women in the village of Abladzo who do not cooperate with male expectations and requirements are acting in opposition to deeply ingrained cultural beliefs and values. Hence self-induced abortion is a strictly secret social struggle determined so in large part by cultural ideology. Here, as emphasised in the literature chapter of the thesis, it should be stressed that use of these Ewe myths is not intended portray an overly deterministic view of their impact on the lives of individual social actors but to build a picture for the reader of the complexity and embeddedness of elements of the patriarchal culture within which local women

negotiate their daily lives and enact decisions. The cultural ideology of female obedience to male will forms a central aspect of the superstructure of the patriarchal Ewe society and its influence should not be underestimated. A woman can lose control over her body as obedience is demanded in the bodily praxis of culturally-defined gender roles. Abuses of social privilege and power do not exist in practice in all male/female relationships in the village, despite somewhat rigidly-defined cultural interpretations of gender roles by many local people. However, the accentuation of binary opposition (disguised as mutual cooperation) within gender roles in this local culture certainly creates a potentiality within the cultural ideology for abuses of power. Male abuse of social power is a part of the lives of some women in Abladzo. In patterns of social relations in the village area, a fine and ambiguous transformation of cultural concepts of female obedience to male will has occurred. Male will and female obedience, defined as 'leadership and cooperation' respectively, has been reinterpreted by some as the concept of female obedience to male *entitlement and desire*. This becomes very much more than an issue of semantics in an African culture where social roles, responsibilities and obligations are taken very seriously (Sefa Dei 1994, p.13).[76] This ambiguity between *will* and *desire* is reflected in patterns of social praxis. Moreover, it is demonstrated in the next chapter as being a reason for some women's disempowerment as their bodies become the object of male entitlement and sexual desire.

[76] Sefa Dei (1994, p.13) states that 'In indigenous African philosophy mutual cooperation is vital for both individual and group survival'. He stresses also ideas about responsibility and duties to others.

Chapter Eight

Marriage: The Customary Union and the Mode of Desire

As stated previously, Marx distinguished between two forms of the superstructure of a society, the philosophical and religious, and the legal. This chapter examines legal forms of the superstructure of the Ewe society in Abladzo village. In particular, the chapter analyses the institution of marriage under customary law. Understanding the nature of marriage in Ewe society is the key to understanding why women perform unsafe abortions in the local area because it is the fundamental basis of the relations of production. It is thus also very much integrated into the superstructure of society by the laws and traditional ideas or, transformations of these, which define patterns of social relations. It is here that I now turn to the theoretical work of Turner (1984) in order to demonstrate the way in which the institution of marriage and patterns of sexual social relations in the local area are very much central to the patriarchal social order. Turner (1984, p.14) calls this link between the social order and socially constructed patterns of sexual relations 'the mode of desire'. The chapter examines 'the mode of desire' in Abladzo and the way in which many women can lose control of their bodies and sexuality as they become the property of their husband in accordance with customary laws. Abusive interpretations of traditional law regarding male sexual entitlement can lead to unwanted pregnancy and subsequent unsafe abortion.

In Turner's (1984, p.14) theory about the mode of desire within a given society, he states that there is always 'a discourse which determines appropriately sexed beings and organises their relations'. In Ewe culture this discourse is predominantly expressed within customary law. The law specifies that correct sexual unions are those formulated within the institution of marriage. A marriage is considered valid if the appropriate customary rites have been performed. In the local Ewe region, a marriage union is preceded by 'the knocking'. This is a ritual act where the family of the bridegroom go to the bride's parents' house at dawn to formally ask for the hand of the bride. On hearing the reason for the visit the bride's parents consider the request for a few days. If they are satisfied that the suitor will be a good husband and the girl agrees, the bridegroom's family are informed on their second call that their

request has been accepted. In return for this information, the knocking fee of two bottles of *akpetisi* [local liquor] is paid to the bride's family. The next stage of a customary marriage involves the giving of a marriage payment which is considered necessary for a legal union. A man wishing to legally marry in a customary way must supply all items from a list written by the bride's parents. This list is essentially a bridewealth payment. After the ceremony the woman is henceforth seen as the property of the husband. This notion of property was confirmed by a local Ewe elder:

Me: *Traditionally was the wife the property of the husband?*

B: *The wife can only become the husband's property if you perform all the customary rites. Then whether she is alive or dead she is for you. If I married you and you are dead, I will get all your funeral ceremony expenses, so you are for me. Ideally, if I pay for you [then] you become my property. So even if my wife's mother is sick and she wants to leave to care for her, she must ask permission from me, the husband. If I allow, she will go. If I do not allow, she will not go to the mother. Traditionally too, although it is sad, our traditional rulings they also say that if you are a woman, you must follow the rules of her husband. But the husband is supposed to be fair to the woman. So if you are not then you may have to pay a penalty to the woman.*

These traditional notions of property also extend to sexual rights over a wife's body. The notion of wife as property continues to be a feature in contemporary marriages albeit to the chagrin of the local women to whom I spoke. They described their views of a customary marriage situation:

W: *So, even for example if a man marry you, and pay your bridewealth and all that...and for example you do something little like the man say 'cook this for me ' but you didn't cook it on the time he want...maybe he can insult you even beat you. He will say that he is the one who marry you, not you...he pay the bridewealth so he like what he want. Sex too.*

Me: *Oh it's like he owns you now because he paid the bridewealth?*

W: *Yeah. (Laughs) It's horrible...it's horrible. Like maybe 99% of the men do it. (Quietly) So it's horrible.*

Another participant stated:

W: *The men never listen. All that they want is sex. Most men think [that] they have paid their bride price…they went to your parents and did everything, so your body belongs to them. They can do and undo anything. They want your body.*

A third claimed:

W: *Before the clinic came into existence we, the women, felt that our body belongs to the men.*

Me: *Why did you feel that?*

[woman groans]

Me: *Sorry, it is a hard question*

W: *The reason why I am saying this is that in the past, you are in a room with only your husband, he can do and undo anything on you. He can force you and have sex with you. But with the introduction of the clinic, you can go in for an injection and if your husband wants [then] you just give yourself to him…*

Me: *So there is still the situation where the woman can't say no to sex but there are no physical results…pregnancy from that.*

W: *Yes*

Some women told me they would be beaten if their husband found contraception at their home. For this reason they said that they, and other women in the community,

preferred implants as a means of contraception.[77] The implants offered them the opportunity to exercise agency over their bodies albeit in a secret way.[78] They all stated that because of the existence of the Abladzo community clinic they had more control over their bodies than they had ever experienced before and so they felt more empowered. However, the provision of contraceptives as a way of attempting to reduce the incidence of self-induced abortion offers some women only a very limited degree of ontological control in the sense that they are given control over the physiological outcomes of sexual practices but not over the act itself. Merleau-Ponty (1962, p.167) claims that 'the body is both an object for others and a subject for myself'. For some of the women who live in Abladzo embodiment in a social sense can also means alienation from their body as it becomes an object of male sexual desire. All of the participants stated that they could seldom refuse a husband's sexual advances.

Sexuality is predominantly distributed through the Ewe society of this region by relations of possession and ownership via the social institution of marriage. The customary laws provide an exterior discourse which facilitates a particular sexual ideology of female subordination and male entitlement. The female body as a social body is thus inscribed with a social sexual reality which may, or as demonstrated by the experiences of the participants of this study, frequently may not correspond to a phenomenologically preferred sexuality of the individual body-self. While the mode of desire, articulated through customary law, is focused at the level of individual

[77] The idea that some women face harsh consequences if their use of contraception is detected is both detailed and overlooked in studies of contraceptive use. The idea that some women face harsh consequences if their use of contraception is detected by a male partner is discussed by Cook & Maine 1987, Blanc et al 1996, Renne 1993, Rutenburg & Watkins 1997, Biddlecom & Fapohunda 1998, Dixon-Mueller 1989. Renne (1993) in particular, provides ethnographic evidence of women who were sent from their marital home for attempting to use contraception without the permission of their husband and no longer wish to risk using the pill (p349). Eschen & Whittaker (1993, p.110), Dixon Mueller (1989, p.147) & Ezeh (1993, pp. 171-172) also argue that women may suffer divorce, abandonment or beatings if they use contraception against a partner's wishes. With regard to partner veto being overlooked, a study of contraception in rural by Ghana Geelhoed et al (2002, p.714) found evidence of women who were 'afraid to use contraception' and subsequently induced abortion as a consequence of unwanted pregnancy. The article did not offer the informants' explanation of why they were afraid but assumed that the lack of contraceptive use was a matter of 'misunderstandings' relating to health concerns about the contraceptive products. It is possible that such fears were instead or also related to partner veto.

[78] Here the key word is 'opportunity' because although the women said that they preferred the implants, in fact none of them were currently using that method of contraception. They said they had not saved up enough money yet. Hence, the feeling of empowerment is more from the idea of what is possible for them now, rather than what they are currently experiencing.

bodies in the everyday lived experience, it is in fact an example of Giddens' (1984, p.3) 'long duree' of institutionalised social practices 'deeply embedded in time and space'. The customary sexual ideology produced and reproduced through social practice is thus a structural feature of local Ewe society. Despite the significant constraints that some women in Abladzo face, they make attempts to achieve more control over their personal body than what would be defined as acceptable by their husbands and by the social body as a whole. Giddens (1984, p.16) warns against conceiving of 'structures of domination built into social institutions grinding out docile bodies who behave like automata'. He argues that all forms of dependence offer ways in which those who are subordinate can influence their superiors (Giddens 1984, p.16). Local Ewe customary law does provide for women as wives in the sense that it requires husbands to be fair. If husbands fail in this regard they are to be sanctioned by the use of fines. While I was living at the clinic, I heard of a family who 'took their daughter back' from a husband who did not exhibit good conduct. However, this did not seem to be the norm. Indeed, in a study of domestic violence in Ghana, Ofei-Aboagye (1994, p.929) claims that many women who had been beaten by their husband had reported the incident to relatives at one time or another, and that in many cases the women had reported their husbands to the chief of the village although it had not helped her situation in any way. If popular interpretation of customary law does not provide married women with a way to influence their superiors lawfully, it is unsurprising that they resort to self-induced abortion as a more independent, secretive means to maintain a degree of control over the body and its processes.

Union Without a Customary Marriage – A Transformation of the Mode of Desire

While the legitimate mode of sexuality is expressed through a customary marriage relationship at Abladzo, more and more young people now forego the customary marriage rites and form culturally-illegitimate unions. Participants described the breakdown of the traditional bridewealth system as the principal factor for the abandonment of traditional marriage customs:

D: *Traditionally, in those days the [number of] males outweighs the females so it was illegal to date or be boyfriend/girlfriend before marriage because if I see you then the first day I must say to your parents that I want to marry you and assume the customary rights. Nowadays the female outweighs the male. So now most people will start with a relationship like boyfriend/girlfriend before marriage but it is illegal to the custom. Every couple, they are from two families, the maternal and the paternal. So according to our [traditional] law in those days Apetetsi, one full bucket [was given to] both the maternal and paternal family of the lady. But a time came when they would judge the man according to the lady and ask for billions of Cedis and at times they can see the man is from a rich family and so they ask more….even billions of Cedis…*

Me: *Do you think that that kind of greed is the breakdown of the system?*

D: *It was, it is and it is still breaking it down.*[79] *That is why…most boys don't have money to start so they just start with the relationship.*

Me: *Do you think western culture impacts?*

D: *Yes, we blame you people the whites, because we the blacks if we go outside the country like to America…we see these ways and we also bring it to our cities like Accra and Kumasi. We will copy it and then it gets to the villages too. So you will be blamed [he was laughing and gestured at me]*.

In Turner's (1984, p.14) theory he argues that 'a social discourse specifies eligible sexuality, not the dictates of human physiology'. However, while the predominant discourse on sexuality is still expressed in terms of customary law and marriage, many young men in and around Abladzo find their human physiology frustrated by the seeming impossibility of the financial demands of the contemporary bridewealth payment. Thus, they simply bypass the customary social regulations and fail to fulfill the customary requirements of an appropriate sexual relationship. While the personal

[79] Zeitzen (2008, p.150) confirms the ubiquitous presence of bridewealth payments in contemporary African societies but states also that 'there has been a drastic inflation in the amount of bridewealth demanded [and that] it is becoming more difficult for men to afford such payments'.

motivations for this are obvious, the unintended consequence has been the degradation of the traditional social structure as a whole and the emergence of new forms of social relations which can create challenges for women. While the customary law sees a wife as a man's property, it also ensured her material provision, at least to some degree. Moreover, it meant that a man could theoretically be sanctioned for improper treatment of his wife. Giddens (1984) theorises that structure is both constraining and enabling. In this respect, the customary law which constrained women by making them sexual subordinates, did at least offer some avenues for protest and provide material and moral support for their existence. For some local women who form unions without the social legitimacy of customary rites, life can be even harder than it is for their married counterparts.

Among some men in the village, there exists a kind of transference of the ideological concept of wife as a culturally accepted avenue for the expression of sexuality, to in fact any woman that a man finds sexually appealing. This is evinced by the way that some men greet a woman they are attracted to as 'my wife' when they are both unmarried. Of course, sometimes this greeting is simply a good-natured joke between friends. However, in some cases the flirtatious greeting implies all of the social legitimacy and social respect a proper customary marriage would offer the woman but can be intended as little more than a sexual advance.[80] Furthermore, the use of the term 'my wife' to a woman who is simply desired in a sexual sense, reflects an effort to maintain the representation of proper social practice and thus a moral self. Unfortunately, the preservation of a moral self- image is sometimes not successful. Sexual unions without marriage carry high social risks for women, as described by participants:

W: *There are some irresponsible men who will pregnate you…they will talk to you nicely and then pregnate you and then abandon you. It is [then] your duty to take care of the child even after it is born; it is your duty because the man has neglected the child. It is hard….too hard.*

Me: *So the woman will be left farming or selling alone?*

[80] It should be noted that this is also at times a harmless social joke.

W: *Yes, farming and trading. You will not be respected in the society. They will say you have got a bastard. Even if the child grows up….that child has no respect.*

Aside from circumstances where the women are physically overwhelmed, it would be perhaps logical to an outsider to ask why the women accept male attempts at sexual unions which are not formally recognised by customary law. The changes in demography play a considerable role in the reorganisation of sexual social relations for women. As stated by a participant, nowadays there are many more women than men in the region. Apart from basic physiological need, in an Ewe community a woman gains much social status from marriage and she is credited with high morality. These factors are tempting reasons for a young woman to believe promises and to ultimately accept less than what she is traditionally entitled, especially if she hopes a pre-marital liaison may lead to marriage.

By far the most emotionally uncomfortable interview in this research was with a woman whom I shall call Rose. She was 31 years old at the time of the interview and has five children to different fathers. Rose is unmarried and has never been so. She spoke very quietly throughout the interview despite giving me very candid answers to my questions. Rose is an example of the difficult life circumstances some rural women face if they do not marry. Rose is illiterate and farming cassava alone is her only way to provide for herself and her children. She said that she has no family to help her and because of her five children and lack of marriage status, she believes that no one in her community respects her. It was very sad to hear her speak about herself this way. She told me that men 'talk to you nicely and impregnate you and then they abandon you'. I had asked her why she continued sexual relations with men who would not be committed to her. She replied that:

R: *[laughed but embarrassed] Sometimes we women can't say no to men.*

Me: *Other women said they found it difficult to say no as well. What situations do you feel you can't say no?*

R: *Sometimes the man will force you and impregnate you and not even take of you and in some situations you have a new boyfriend who comes and you can't refuse him sex so…[voice trails off]*

Me: *Why not?*

R: *Because you have not seen him before and he has been in love with you so you can't refuse him sex…you have to. He has been coming to you all the time. The first time he comes to you or to your room…you can't refuse it. It might mean you are very ungrateful.*

There is a sign on the wall inside the community clinic which reads 'if your gift is for sex, then keep it'. The sign has a picture of a local man soliciting a young woman. She has her back turned away from him. Unfortunately for some young local women it is not so easy to turn their back from the man and his 'gift'. When local men court a woman, they bring gifts of food, clothing or money. Rose's fears of accusations of ingratitude refer to the social expectation that sexual services will be provided in return for these 'gifts'. Zeitzen (2008, p.164) describes these patterns of exchange claiming that 'the system allows women to maintain the traditional pattern of men assuming responsibility for their financial outlays in return for sexual relations'. Zeitzen (2008) mainly discusses this phenomenon with regard to urban Ghana, particularly in the cities such as Accra. However, such relationships occur in the villages also and they illustrate the point made by a previous participant who claimed that the breakdown of the traditional system of marriage was in part related to new patterns of sexual relations in the cities which had made their way out to the villages. Although the participant blamed the changes in social relations on 'the whites', in fact the changing patterns of sexual relations are essentially highly complex forms of polygamy and have at least as much in common with traditional African beliefs as contemporary western attitudes (Zeitzen 2008, pp.163-164). However, Zeitzen (2008) also highlights the fact that for most women such arrangements are in the long-term unsatisfactory because women have to provide the same 'services' to men as in a customary marriage but they do not get the same socio-economic security in return. Moreover Zeitzen (2008, p.164) claims the 'relationships are usually very insecure and may leave the women destitute if the boyfriends lose interest in them', hence

Rose's explanation that she cannot refuse to have sex with a boyfriend. Without financial resources for contraception or partner co-operation, another pregnancy for Rose is the likely outcome of her social circumstances. Previously, she has dealt with unwanted pregnancies twice by using the *babati te* plant to induce abortion.

The circumstances described above demonstrate why some local women resort to self-induced abortion to deal with the unintended consequences of unions which are not legitimate within customary law. Goffman (1971) describes the techniques of 'face-work' employed by social actors who find themselves (potentially) compromised by social stigmatisation. He describes the ways in which social actors at times assert conscious control over their physicality in order to avoid social disapproval or embarrassment. In performing a self-induced abortion, the women at Abladzo village do very much the same thing, albeit to a much greater degree. The social stakes are so high for these women and abortion is a way to maintain a representation of self which conforms to the socially prescribed morality. Many of the participants in this study chose to exercise agency via the medical assistance offered by the community clinic rather than the social mechanisms provided by customary law and kinship networks, precisely because they did not have customary marriages. In attempting to provide local women with support, the clinic is thus very much a part of a dialectic of control in the social relationships at Abladzo. In providing contraception and medical assistance it offers women methods of coping with the transformation of these aspects of the traditional social structure and the new sets of social relations which have emerged.

Chapter Nine

The Community Elders and Abortion

Clearly, in the village a woman's body is not simply her own to do with as she would wish but it is also very much a social body, embedded in multiple sets of relationships and subject to social regulation. The participants described how their bodies, as part of the social body, were subject to sanctions if it was discovered by community elders that they had committed an abortion. In an Ewe community, abortion is considered an act of homicide and is very much against customary law (Ametewee & Christensen 1977, p. 361).[81] The women who attempt abortion and cannot control the bleeding, run to the clinic only at night. Under the cover of darkness and the integrity of the local clinic director, the women's secrets are assured. They are protected from the possibility of financial, social and even spiritual penalties.

W: *If one does it [abortion] at home you can never know.*

Me: *So confidentiality is a big issue?*

W: *Yes, because when the elderly get to know, you will be fined.*

Me: *The elderly people in the village?*[82]

W: *Yes, it is a crime over here. When they see that you have caused an abortion you are cremated when you are dead.*

Me: *Oh really? It is like punishment for witchcraft….*

W: *Exactly*

[81] Ametewee & Christensen (1977) argue that in the Ewe Region of this study abortion is considered an act of witchcraft therefore a practice done by a witch. However, local Ewe in this research explained that both abortion and witchcraft are punished by cremation but a woman is not considered a witch for inducing abortion. The participants did concur with Ametewee & Christensen's argument that abortion is seen as an act of homicide in the local Ewe culture.

[82] It was difficult to believe that the same warm, loving elderly people that I have been interacting with during my time at the village, would inflict such a punishment on the young woman that was sitting in front of me.

Me: *Is it?*

W: *Yeah. There are still red lines in existence over here that if you cause an abortion, you will be cremated. That is why it is so secret. Even though most women do it, it is hidden. In their opinion [the opinion of the elders] if you cause an abortion and the foetus is out, it means you want to kill someone or you are there to kill someone or you can kill someone.*

Me: *So what happened in the past?*

W: *The same thing. They would cremate your body after you die and it is a shame to the family and nobody attends the funeral.*[83] *When you are alive and the family gets to know you are causing an abortion, you would be called and fined and you pay the penalty and that is all. So it means that if you have paid the penalty, you have compensated the gods. You pay the elders. They take a ram from you and some bottles of schnapps and some bottles of local drink.*

Me: *Wow, it is good to be an elderly fine taker…*

[All laughed]

Me: *And the same thing happens now?*

W: *Yes, they do the same fine and people get to know that you are causing an abortion.*

Me: *But what about the cremation, does that happen still as well?*

W: *Yes but….. if nobody knows then….most of them never know. People cause abortion in their own house but they [others in the community] never know. I tell them I am having a headache and nobody comes.*

[83] A funeral is a time for great public enjoyment and to have no one attend your funeral ceremony is a source of extreme social disgrace for Ewe (personal communications).

To abort a pregnancy in an Ewe community in this region is a crime. A woman who does so is acting outside the rules of the social order. She is a killer. The symbolism of this label is quite profound. In the village, a woman is seen as the producer of life. Her body produces and reproduces the human members of the community. Essentially a female body-person makes life and nourishes and supports it. However, by performing abortion she is in fact taking life. She has transformed herself from the producer of life to the destroyer. By inducing an abortion she is not just taking the life of one foetus but by symbolic extension she is destroying the life of the community. Abortion as a social practice is a complete symbolic reversal or opposition to the socially prescribed role of the female in Ewe society. The application of the same punishment as used for witches is not surprising under further analysis. One of the primary attributes of witches is that they do things in reverse of the natural or ordinary ways. A local man described the activities of witches to me as 'upside-down' that 'when they are doing something bad it is good to them…..it is good in their kingdom'. He described the activities of witches as something opposite to the normative order, particularly in a moral sense. Women who abort pregnancies are acting in violent opposition to their designated social role and are therefore considered a threat to the entire social order.

The Ancestors and Abortion

The hierarchy of authority over a woman's social body does not rest with the elders alone. Turner (1984) describes the presence of immaterial bodies as part of social systems of regulation. He states that in some cultures 'there are also immaterial bodies ... [who] may have major social roles and important social locations within the system of stratification' (Turner 1984, p.8). In the village of Abladzo the bi-lineal ancestors are watching everything. These immaterial social entities are invoked as part of the regulating structure of social life. To earn their disapproval is shameful. One participant described the relationship with the ancestors:

W: *Our past ancestors are still in the distance….looking on the planet or they are still on the planet looking at what is going on and during their time they have never had that. They never did any abortion so if a young man or a young woman does that now,*

it means that the past relations who are dead are still looking so to serve as a deterrent they [the elders] have to do it [punish].

The ancestors exist in the village very much as an ontological reality. They are presented as models of perfect behaviour to be emulated. They also serve to legitimate the authority of current community elders. Members of Ewe society who do not live up to these ideals are sanctioned by guilt.[84] Meillassoux (1972, p.99) emphasises the temporal nature of social structure in rural societies in West Africa arguing that 'time and continuity are essential features of the social organisation' of self-sustaining agricultural communities. He states that there exist successive working generations which change over time. Older members retire or die and younger members take their place. At one time or another all the workers of one generation are indebted to members of the previous generation. As time goes on the cycle theoretically continues and a generation changes (Meillassoux 1972, p.99). The intention here is not to portray an endless, unchanging cycle of tradition as the only economic and social activity of the village. This is not the case. However, for many social actors in the village area, the social and economic process described by Meillassoux (1972) is accurate. This way of life creates what Meillassoux's (1972, p.99) observed as 'the lifetime association of personalised bonds' and the 'priority of relations between people'. Such relations extend also to ancestors who in accordance with Meillassoux's (1972) reasoning are due thanks for their social and material contributions to society from which the living now benefit, including life itself or the fact of having been born. A young male local told me that:

S: *Every tribe will never hesitate to perpetuate their own lineage.*[85] *Lineage was something being inherited from the ancestors long ago and it must be followed from [one] generation to the next. For history to repeat itself, every tribe will never allow it original lineage to fade into the dust or be influence by any external forces or beliefs.*

[84] In accordance with Giddens's (1984) theoretical position that structure is both constraining and enabling, it should be noted that the ancestors also serve as a source of great support for local Ewe. They can supply advice in dreams or intervene spiritually in daily affairs for the good of their supplicants.

[85] The participant used the term 'lineage' although he is not referring to a lineage in a strict anthropological sense. He is discussing the patrilineal descent lines belonging to the various agnatic clusters in the local area, as well as a sense of perpetuating the particular Ewe tribe to which he belongs.

It is said that tradition dies very hard and for that matter mother tongue Ewe men have inclination to keep their cultural values at all times.

Of course by physiological default the manifestation of the idea of reproduction of human beings as an obligation to the ancestors is placed on women. This notion was clarified to me by a local male in his late twenties. He told me that abortion was very wrong because a woman was born, so in a reciprocal sense she should certainly give birth. The relations between people are of great importance in Abladzo and one's place in society and its obligations are an important part of social being which emphasises social responsibility, connectedness and belonging to the group (Sarpong 1974). While such collective responsibility has numerous social and material benefits, it also places individuals in positions of obligation or social conformity which may make it more difficult to act in one's own best interests. This is certainly the case with regard to pregnancy. A woman's body is seen as instrumental to the historical succession of the lineage and the social body of the Ewe ethnic group as a whole. This view of the social can sometimes be emphasised over the wishes and sometimes even needs of the female phenomenological individual body-self.

Abortion and Cremation

Participants described the use of cremation as a sanction against abortion. This punishment is particularly severe because it is essentially expulsion from the planet. The customary laws and traditional beliefs are embedded in extensions of time-space by the production and reproduction of social practices such as the cremation ceremony known as *Hoametordzoe*.[86] The ritual burning of a woman's body under ceremonial conditions serves to reinforce the structure of local Ewe customary law as stretching even beyond the limits of this physical life. The social risk for a woman causing abortion is immense because if discovered, the act has cost her the opportunity of returning as a respected ancestral [spiritual] presence within her community. Even more severe, it has cost her her spiritual union with the creator God, *Mawuga*. A participant described the punishment like this:

[86] 'Ho' means taking out of soil. 'Ame' means human and 'Tordzoe' means burning.

W: *If you cause an abortion and you die, they cremate you.*

Me: *…and I heard that the cremation is that so that you don't come back as an ancestor?*

W: *It is just like a punishment or to serve as a deterrent to your children who are alive….that your mother did this thing and was burnt and you, the daughter should not do it. They feel that the body is part of the soul so if they burn it when you cause an abortion you are out of the planet.*

Me: *So you are out of the planet and you don't come back as a spirit?*

W: *Yeah. You will not even go to Mawu*

Me: *What… you don't go to Mawu?*

W: *No, you have offended Mawu.*

Me: *So where do you go?*

W: *You have offended Mawu so you are not going.*

Me: *Where are you going?*

W: *You will be hanging.*

Me: *Just hanging around?*

W: *Yeah, hanging around.*

Me: *Do you believe that?*

W: *Nobody has ever been cremated and come back to report about it.*

As demonstrated above, the customary laws and traditional beliefs that are present in village life are rules which create the binding of time-space of the Ewe social system in this region. These rules are the properties which make it possible for discernibly similar social practices to exist in time-space. The use of rules allows the constitution of meaning as well as sanctions which in turn help to produce and reproduce similar social practices (Giddens 1984). In the village, the sanctions for abortion are heavy. In particular the use of shame and social ostracism were described by participants. Moreover, the threat of spiritual dislocation (described as 'left hanging around') is also imminent. While these sanctions function to maintain the production and reproduction of local Ewe society, 'social reproduction must not be equated with the consolidation of social cohesion' (Giddens 1984 p.25). Giddens warns against reductive theories of consciousness which attempt to present social life as governed by 'dark currents outside the scope of actors awareness' (1984, p.5). I believe this is particularly relevant with regard to the discussion of African traditional beliefs and social practice in a rural village. All the participants of this study demonstrated a high degree of ability to rationalise within a diversity of circumstances of interaction. None of the participants were simply blindly adhering to all aspects of 'traditional belief' if they considered these too detrimental to their personal or social well-being. While they were clearly familiar with the forms of everyday life expressed in patterns of social relations and activities, giving them 'knowledability' in Giddens's (1984, p.3) terms, they also had reflexivity in the sense that each woman was able to 'monitor the character of the on-going flow of social life' and find spaces where she was not bound to ritual or ideological cultural conformity and she could act (Giddens 1984, p.3). While these women adhere to much of the traditional structure of the local Ewe society, they are also selective and choose to disregard some parts of the sanctions, such as the threats of spiritual dislocation. In addition, they actively find ways around the social regulations such as performing abortion at home and saying they have 'a headache' to maintain secrecy. The social practice of self-induced abortion is thus a courageous form of agency for women who have significant constraints placed on them by the sociality of their bodies.

PART THREE – The Political Body

Chapter Ten

The concept of a body can be seen as a phenomenological individual body-self and a social body, as has been demonstrated by parts one and two of this work. However, the body must also be seen as 'a body politic, an artefact of social and political control' (Scheper-Hughes & Lock 1987, p.6). It is now from Scheper-Hughes's & Lock's (1987) third perspective of the body that the social practice of self-induced abortion at Abladzo is analysed. To the reader it may appear initially that the anthropological gaze has moved away from the causes of unsafe abortion and that these are located in the village. However, this section of the thesis highlights the 'missed identification between the individual and social bodies' made possible despite, and perhaps in some ways because of, political interpretations of women's bodies and health (Scheper-Hughes & Lock 1987, p.10). Despite being a very rural community, the social actors living at Abladzo are still citizens of the Ghanaian state and are therefore eligible to receive the assistance and provision of public health services. However, by and large they do not. To a significant degree, the fact that many women in the village continue to perform self-induced abortions is a social manifestation of the political inequalities inherent in the Ghanaian public health sector. The following chapters demonstrate the ways in which public health endeavours facilitated at the political level of both global and national influence, fail to make an impact and reduce the incidences of unsafe abortion in Abladzo village.

Ghanaian Public Sector Health Care

Essentially, since colonial times Ghana has operated under a pluralistic healthcare system.[87] Like many Sub-Saharan African nations, the state provision of health services has largely been based on models of western institutionalised healthcare which were imposed during colonisation but nonetheless maintained from Ghana's political independence in the late 1950's. Despite investing in a hospital-based model of healthcare, the Ghanaian state found that it could only afford such a system in the

[87] See Twumasi, Patrick A (1979, pp. 349-356).

larger cities and some towns. It is widely recognised that upwards of 70 per cent of available healthcare resources are spent in urban hospitals that are accessible to only 30 per cent or less of the population (Parry et al 2004, p.89). In this respect, the state fails to provide allopathic healthcare to its rural populations and the vast majority of those living in the countryside rely on traditional medicine such as herbal treatments.

However, the Ghanaian state's capacity to offer health services to its population cannot be separated from the structural realties of Ghana's place in the global political economy. Economic and social advances made by the state post-independence, were thwarted by worsening terms of trade during the 1970s oil crisis and the global economic recession which followed in its wake. Stringent economic policies adopted by the northern nations from the early 1980s meant reductions in spending which flowed on to Ghana through both reduced demand for exports of primary products such as cocoa and a steep decline in aid. These economic challenges were too much for the fragile economy of the newly independent nation and it experienced a reversal of capital in addition to acquiring enormous debt. This made Ghana dependent on the conditions of aid offered by the International Monetary Fund (IMF) and the World Bank (Pinkney 2009, p.30). Like that of its Sub-Saharan neighbouring nations, the aid offered to Ghana came in the form of Structural Adjustment Programmes (SAPs), an economic dogma which imposed stringent debt repayment plans and liberalised global trade.

While the benefits of SAPs have been recorded at the macro-economic level, the advantages at the micro level of everyday life are hotly contested (Konadu-Agyemang 2010). A wide range of academic literature attests to the socio-economic and spatial disparities created by SAPs; in particular the literature emphasises the reduced provision of social services, such as healthcare.[88] The subsequent restraints SAPs placed on the government of Ghana led to wide-spread expansion of Non-Governmental Organisations (NGOs). The NGOs were increasingly seen as an international support mechanism which could provide services… and advocate on behalf of the poor (Pinkney 2009, p.40). Hence the terms 'debt relief, participation

[88] These spatial disparities refer in particular to the increasing gap in service provision and facilities offered to urban and rural citizens of Sub-Saharan African states. People in rural areas receive considerably less social service provision than urban dwellers.

and empowerment' now commonly associated with global aid and development strategies, gradually emerged in political discourses about Africa (Pinkney 2009, p.43). Unfortunately contemporary debt relief remains limited and conditions for receiving it are restrictive and highly bureaucratic. The inequalities present in the global political economy have seriously reduced the ability of the Ghanaian state to gather the financial resources to maintain adequate healthcare budgets and ensure satisfactory levels of service provision in the public health sector. This is especially the case in rural Ghana.

The brief overview of the politico-economic factors present in the history of Ghana's health services offers insight into the challenges faced by the state, but also serves to contextualise the following chapters by showing the way in which Ghana is enmeshed in global relationships at the level of the body politic. These relationships are imbued with global concepts of public health and ideological flows which create discourses about health and its provision to be enacted at the level of the state. Scheper-Hughes & Lock (1987, p.26) argue that 'cultures are disciplines that provide codes and social scripts for the domestication of the individual body in conformity to the needs of the social and political order'. The use of 'culture' in this context refers to the culture of the educated elite social actors who produce and reproduce the social scripts or discourses about bodily conformity in the interests of public health as defined by the global political order. An example of this are the Millennium Development Goals set forth in the year 2000, by the United Nations as part of its 'Health for All' global development plan. As stated previously goal five of this plan was dedicated to a focus on maternal health. The United Nations stipulated that encouraging family planning was critical to worldwide sustainable development and poverty reduction. This supervision of population at a global level or 'bio-politics of the population' is then subsequently enacted at the level of the Ghanaian nation state in family planning programmes (Foucault 1978).

Conflicting Discourses

With regard to global politics, there is probably much to be gained from adhering to these health aims. However, while many of the women from Abladzo who participated in this study would agree that having fewer children is a way to reduce

poverty and increase health outcomes, I was told that many of the village men would not. As described in chapter four, many social actors and in particular men of the village, do not subscribe to post-Malthusian global political discourses which equate the 'reproducing body as the harbinger of the disordered society full of starving bodies'(Gallagher 1986, p.85). Rather, they see the production of large families as a way to ensure economic success and future security in an agrarian lifestyle. Medical anthropologist Kleinman (1995) advocates writing from the margins, and argues that much relevant knowledge can be gained by analysis of those lives that exist almost in a liminal zone on the edge of experience. Many of the women of Abladzo literally and metaphorically live on the edge or margin. As rural social actors, they live far from the city centres where resources are most plentiful. Moreover, there is also a great distance ideologically and socially from the experience of educated elites who live in the cities and produce the discourses of a politically correct sexuality attained largely by the use of bio-medical intervention, and of course, at a price. For the international body politic, the women of Abladzo exist as political bodies to be disciplined, regulated and controlled for the stability of the nation in a Foucaultian (1978) sense. The sexuality inscribed on their bodies is a political sexuality of discipline and control, a measured and responsible sexuality which monitors and limits its production for the good of the nation as a whole. The point here is that the women of Abladzo are caught at the margins of two different social worlds which assert competing discourses about sexuality and reproduction, but it is the women whose very bodies are at the centre of the issue. It is they who must negotiate their everyday lived experience between these discourses of control as best they can. Very often, it is simply not possible for some women to fulfil the expectations of embodied regulation placed on them by global interventions politically endorsed by the state.

The use of self-induced abortion is not recognised by the state or by public health sector professionals as a desperate but necessary measure for individuals who see no other option. Rather, it is seen by some stakeholders as something blameworthy and foolish. It is seen as something undertaken by those who choose not to uptake the services of the state because they are irresponsible or ignorant. In 2007, the African Union Conference of Ministers of Health agreed to adopt strategies to reduce unsafe abortions by providing services to the fullest extent that country laws allow (Hill et al 2009, p. 2017). Ghana upgraded its services as far as its health budget would allow

and it was hoped that results would be seen as a reduction in the number of induced abortions. Indeed, the fact that there are still numerous incidences of unsafe abortions throughout Ghana does not escape the watchful eye of the state health services. A recent article in a Ghanaian newspaper reports the frustrations of the Asante-Mampong Municipal Health Director, Rebecca Dokorugu. She has called on women 'to take advantage of safe family planning methods, to avoid unwanted pregnancies, unsafe abortions and preventable deaths [and she] regretted that in spite of the numerous government interventions to safeguard their reproductive health, women are still dying from unsafe abortions, *due to ignorance and non-patronage of available family planning methods*'.[89] Similarly well-intentioned, the Medical Superintendent of the Mampong Government Hospital, Doctor Emmanuel Ahiable, advised women to 'desist from engaging in self-induced abortions which could easily kill them [and to utilise] safe abortion services provided at hospitals at a reasonable cost. [He also] called on men to undertake the vasectomy'.[90]

None of the women who participated in this study were unaware that self-induced abortion could kill them. Neither were they ignorant about the services offered to them by the public health sector. They explained their non-patronage of the local hospital in the following ways:

Me: *Can I ask why the women don't go to the hospital when they are bleeding? Why do they choose the clinic?*

W: *The first [reason] is the distance. The distance from here to the hospital is far but here [at Abladzo clinic] is so close.*[91] *If you come here, your life is safer than going to a far-away hospital.*

Me: *Right…ok. So what did women do in this area before the clinic? What did they do about bleeding?*

[89] See http://www.ghanaweb.com/GhanaHomePage/health/
My emphasis.
[90] Ibid
[91] It is over 20 kilometers to Sukli Hospital from Abladzo village.

W*: I am young, but I was told that before the clinic any woman who has a difficulty has to be taken to hospital. If there was no vehicle then the woman should be carried on the heads [of others]*

Me: *Wow, walking?*

W: *Yeah in a lazy chair*

Me: *What ….a what chair?*

W: *We call it a lazy chair*

Me: *…and they carry them. So what about…*

W: *It's just like that wooden chair over there…* [points to an ordinary, wooden outdoor chair]

Me: *Oh. What about if it's a case like an abortion and you don't want people to know? How can some women get the support for someone to carry them?*

W: *That causes the death of many young girls because they determine it to be secret. They never tell anybody so they keep on bleeding, bleeding bleeding….and they die.*

There is a vast amount of academic literature which attests to the problems faced by rural social actors when trying to utilise public health services (Hord & Wolf 2004, Tsey 2011, Okojte 1994). Distance is often cited as a key reason for non-patronage of local hospitals. Moreover, in the rainy season many rural areas in Ghana become inaccessible by road. Although I did not visit Abladzo during the rainy season, there were still days when it had rained and it was impossible to travel on the local roads because the rains had turned them into rivers of mud. In addition, for a rural person the cost of a hospital visit is also a very significant barrier to health provision from the public sector. Almost all of the women I interviewed at the village were farmers. Although this was sometimes combined with petty-trading, the income accrued from

these activities was, according to the women, not enough to allow visits to a public hospital. They explained that:

Me: *Why don't more women go to the hospital for assistance?*

W: *We have no money. I can't even pay transport to get to the door. If you ask the price to the person and you have no idea what it will cost…my herbs are better than this. They are better medicine and they are free.*

Another participant stated:

W: *Although the clinic is here, we don't do abortion [at Abladzo clinic] and I have no money that is why I am undertaking my own herbal medication. People who have money…they go to the hospital for their abortions.*

Me: *But most people in this area do herbal abortions?*

W: *Yes.*

Another participant explained that a lack of financial resources was a reason for non-patronage of the local hospital but also that she felt that the hospital staff were unprofessional and hence she was unable to trust the hospital services:

Me: *Why don't the women go to the hospital for the abortions…why do they do it themselves?*

W: *My own local medication is better than that of the hospitals*

Me: *Really…so you think that the hospital medication isn't good?*

W: *My medicine is better than the hospital's and….. on some occasions, I wouldn't have money at that moment.*

Me: *Ahhh…I see. So it is financial as much as anything?*

W: *Exactly*

Me: *What does it cost at the hospital?*

W: *Some time ago, we learnt that if the foetus is one month they charge 60 Cedis so three months is 120 Cedis. So each month the price goes up. They can tell lies. The doctors can tell you oh, your pregnancy is three months when it is two months….*

Me: *…to make more money?*

W: *Exactly*

While there exist bureaucratic claims about the success of the National Health Insurance scheme in Ghana, Oxfam has reported the scheme's ineffectiveness in ensuring that Ghana's poor are provided with healthcare options from the public sector.[92] The scheme was established specifically to make healthcare more available to the rural poor such as those in Abladzo village. However, not one person I spoke to while living at the clinic thought the new scheme was successful. Most of those I asked stated that they did not even have the money to join the scheme and even those who would be permitted to join for free, such as those over 80 years old, did not wish to join as they felt that they were unlikely to receive adequate care if they did not pay cash.[93] None of the participants who had undertaken self-induced abortions had

[92] See Dogbevi, (2011)'Ghana's Health Insurance not Working for Many – Oxfam' at http://www.ghanabusinessnews.co./2011/03/09/ghana5E2%80%99s-health-insurance-not-working-for-many-oxfam/
See also Essah, (2010) 'There is Rot in the NHIS – GMA' at http://www.newtimes.com.gh/story/1506

[93] One particular elderly man aged 80, told me that he felt quite sure that he would receive inferior medicines if he did not pay cash. He believed that staff at the hospital gave the appropriate medicine if the patient paid cash. If the patient did not pay cash then he believed that he would not receive an appropriate treatment because the staff told him that the medicine currently available at the hospital was not the most suitable for his ailment and that they required cash to purchase what he needed. Alternatively he was told he was free to go and purchase the more suitable medicine himself. Many other local people told me the same thing as the elderly gentleman and believed that some healthcare workers took the best medicines and sold them privately for personal financial gain thus making them 'unavailable' at the hospital.

registered for the scheme for the same reasons. The participants also expressed a fear of disapproval of abortion from the local healthcare workers at the hospitals:

W: *Any hospital…if you cause your own abortion and you go there and they see the stick [stem of plant], they yell at you.*

Me; *How do you feel when they yell at you?*

T: *In my experience I have never gone to the hospital after an abortion…but [other] people are being yelled at.*

Me: *What does the hospital say about the stems?*

T: *That they did it in the wrong way*.

Also that:

W: *In Ghana we think abortion is illegal.*

Me: *Is it illegal by the Government?*

W: *Yeah, it is legal but… Yeah it's a sin because according to their traditions and even we think that if we do that we sin against our God and other smaller gods. So we thought it's illegal [prohibited]*.

Me: *Right. So obviously some people still do it even though the tradition is that it's a sin...*

W: *Yeah...that's why they try to abort it themselves in the house. They don't want to go to a hospital and do it though we have a hospital in our country and even at Tema who are doing those things.*

Me: *Do you think that if you go to the hospital people will treat you badly?*

W: *They didn't treat them badly but they thought it's not fair to do it. Maybe if they go to the hospital and people know that this is what they are doing...you know, it's not good….*

While it would be a rational possibility to consider that the participants may compensate for being unable to afford a visit to the hospital by finding fault with the health service staff, I do not think this is the case. Hill et al (2007, p.2018) claim that one factor relating to Ghana's unmet need for safe abortion services is the negative attitudes of providers. They claim that in the main teaching hospital in Kumasi, more than 50% of the healthcare workers reported that they would be unwilling to play a role in performing pregnancy terminations.[94] It seems that if this is the attitude in a large city such as Kumasi, then there is a strong likelihood that some of the women from Abladzo do face the discouraging attitudes they describe above from healthcare staff in a more conservative rural region. Moreover, while undertaking participant-observation at the clinic, I heard of the problems experienced by the international volunteers who were trained medical staff in their respective countries. On more than one occasion when the international volunteers interacted with local hospital staff, they were quite shocked by the attitude of the local staff towards the patient. The international volunteers described the staff as being superior, non-accommodating and often very lacking in professional skills. It is very unfair to label women who abort pregnancies themselves as 'ignorant' or to blame them for not utilising public services which are in many respects beyond their reach.

[94] Morhe et al (2007) conducted a study in the Komfo Anokye Teaching Hospital in Ghana and found 45% of responding physicians unwilling to perform an abortion although the majority agreed to the establishment of abortion units in national health facilities in Ghana. See also Hessini et al (2006, pp.20 & 22) & Lithur (2004) for a discussion of the negative attitude of healthcare workers in Ghana and the importance of destigmatising abortion and the women who choose to have abortions.

Chapter Eleven

Ghana's Reproductive Health Strategic Plan

This chapter examines again the fact that the discourses about sexuality and reproductive health produced and reproduced at the level of the political body overlap with discourses at the level of the social body. As described in chapter eight, the overlap is not a gentle merge of contrasting ideologies but a wall of strongly conflicting values played out in everyday social practice in the physical, financial and emotional terms of the lives of real people. This chapter is an analysis of the second location of the overlap of discourses of sexuality and relates to key components of Ghana's Reproductive Health Plan 2007- 2011. The plan itself was established by the Ghana Ministry of Health (MOH), which formulates and advocates health policy and is responsible for its targeted outcomes. It was written to provide a framework for a program of action and to reflect Ghana's commitment to reproductive health in accordance with global development goals.[95] The plan is very detailed and espouses commitment to a holistic view of reproductive health for the nation. It describes reproductive health as a critical component of general health and acknowledges the fact that reproductive health is affected by the broader context of people's lives, noting economic circumstances, gender relationships and the traditional and legal structures within which individuals live.[96] It provides extracts from the International Conference on Population and Development (ICPD) programme of action:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functioning and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and have access to safe, effective and affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law…

[95] See Reproductive Health Strategic Plan 2007-2011 (Introduction).
[96] See Reproductive Health Strategic Plan 2007-2011, p.2

ICPD Program of Action, para. 7.2

Ghana's Reproductive Health Strategic Plan 2007-2011 also recognises that reproductive health is a human right. It cites the United Nations Family Planning Association (UNFPA) claiming that:

Reproductive rights encompass the right to reproductive and sexual health throughout the life cycle, reproductive self-determination, including voluntary choice of marriage and childbearing, and sexual and reproductive security, including freedom from sexual violence and coercion.

(UNFPA, 1997)

Indeed, the plan cites further the importance of human rights for women in relation to reproductive health by claiming in its objective 3 that:

Particular attention is paid to the issue of gender in sexual and reproductive health, respecting the inherent rights of women as equal partners in sexual and reproductive health decision-making. [and that] Inter-sectoral collaboration, especially with the Ministry of Women and Children's Affairs (MOWAC) will be key in promoting gender equality and the empowerment of women (p.11).

Obviously these discourses are aimed at the level of the body as a political artefact. It is an attempt to codify the mode of desire via another discourse of sexuality that is politically desirable to global opinion within the political context of current human rights agendas. The state is defining appropriate social relations and what kind of sexual unions are legitimate and desirable for the body politic. The Reproductive Health Strategic Plan allows for the reproduction of human beings, but also outlines the methods of restraint, in this case joint decision-making and family planning. Here the mode of desire is focused on the dimensions of individual bodies and populations, and the moral regulation of bodies is brought about under the auspices of health (Turner 1984, p.211). An holistic sexuality of responsibility (but in freedom and choice) and satisfaction and equality is offered by the plan. This holistic sexuality is to be inscribed on the body politic via various mechanisms of state, medical technologies and individual compliance. Such high-minded ideals are formulated for

application to the political body as a whole and possibly reach some lucky individuals, but they do not reach most of those in the village of Abladzo.

Violence, Coercion and Ghanaian National Law

It was very uncomfortable to hear the participants in this study describing their sexual experiences as often involuntary, coerced and violent. There was nothing that I could say to improve or change such a situation. Participants explained that rape was a common occurrence in the life of a woman and that it happened in both casual and marital relationships.

Me: *Right ok. So a husband will take his wife and have sex by force. Does this happen between people who are not married – boyfriend and girlfriend for example?*

W: *It happens between boyfriends and girlfriends too.*

Me: *A lot ?*

W: *Yes. A lot.*

I expressed my concern about the frequency of rape in the lives of many local women to an elderly educated Ewe man who lives in a nearby town:

Me: *There are women who are regularly raped….*

.

Dr. *Yes, you are right…it is not surprising. It is the same traditionally. It is not as severe as it was traditionally because now the law is active. Now we have an Act for women and children. If you follow that Act the law will deal with you…the international law…the Government… not the local [customary] law. Now with our new legislation…no matter how you pay for the woman you must respect her view.*

Me; *But in Abladzo it seems not to have changed that much for so many of those women…*

Dr. *It is literacy…they are very agrarian and have no education. They know nothing about their rights.*

Me; *Wow, an education is powerful, isn't it?*

Dr. *It is powerful. Without education...they are overburdened.*

However, gradually it became clear that a lack of education was not what hindered some women from attaining their human rights. All of the women I spoke to understood the national law about marital rape. One participant explained the situation like this:

Me: *Does the concept of rape within marriage exist here?*

W: *It exists in law but if you have to provide evidence against your husband, then there is no point sending him to court. So I have sympathy on him.*

Me: *That's the second time I have heard this idea of sympathy…what do you mean? Sympathy for what?*[97]

W: *If you take him to court, probably the little money you have in the house for the family you will use at the court because in Ghana going to court means you go for two years even for your request. So the man can use that money in travelling up and down [from village to court] and has no money to look after the family.*

Me: *Do men understand the idea of rape within marriage or does he see it as something different?*

W: *They don't care.*

[97] The woman uses 'sympathy' in the sense that she has to forgive him.

Instead of there being some deficiency in the abilities or skills of the women in accessing their legal rights against rape (in this case illiteracy being 'conversationally-substituted' for ignorance) the problem lies, in part, with equality within Ghanaian national law. Ghanaian legislation on marital rape has a history rooted both in colonial and traditional perspectives of the marriage relationship which do not accept a revocation of consent to sex under any circumstances. The imposition of British colonial law continues to influence Ghana's legal system. Ghana's Criminal Code had its roots in British Common Law which reflected an era in Britain when women were not regarded as persons once they were married. After marriage, the spouses became one legal personality and the 'one' that was created in a legal sense was the husband. Therefore it was impossible for a husband to rape his wife in a legal context. Although British law abandoned such notions, Ghana continued until very recently to maintain these ideas under its Criminal Code. [98] Indeed, section 42 of the old Criminal Code provided guidance as to the consent to the use of force, stating that:

'A person may revoke any consent which he has given to the use of force against him, and his consent when so revoked shall have no effect for justifying force; ***save that that consent given by a husband or wife at marriage, for the purposes of marriage, cannot be revoked until the parties are divorced or separated by a judgement or decree of a competent court'*** (Archampong & Sampson 2010, p.508). [99]

Clearly, a spouse could not claim that she had revoked her consent to sex as it was considered a marriage right. In short, there was no crime of rape within Ghanaian marriages. In more recent times a Domestic Violence Bill arose out of the women's movement in Ghana which attempted to repeal the marital rape clause in the Criminal Code by drawing attention to Ghana's 1992 Constitution[100] as well as the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW). [101] The coalition faced numerous challenges from the Ghanaian Government, the media, the

[98] See old section 42 (g) of the Criminal Code and old section 31.
[99] See Nancy Kaymar Stafford (2007-8) 'Permission for Domestic Violence: Marital Rape in Ghanaian Marriages'.
[100] Republic of Ghana, Constitution of the Republic of Ghana, 1992 (Accra-Tema: Assembly of Ghana Publishing Corporation, 1992).
[101] See Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Resolution 34/180, 34 UN GAOR, 34th Sess., Supp No. 46, UN Doc. A/34/46 (1981); 1249 U.N.T.S 13 [CEDAW].

public and Parliament before the Bill was rejected (Archampong & Sampson 2010, p. 509). In May 2006, the Domestic Violence Bill went before the Parliament again and an Act was passed in 2007 which provides that 'the use of violence in the domestic setting is not justified on the basis of consent' (Archampong & Sampson 2010, p. 509). While this was certainly a victory for those advocating the change, the Bill did not refer specifically to marital rape. However, several months later a further legislative change led to the removal of the marital rape exemption under section 42 (g) of the Criminal Code. The laws currently operative are the *Laws of Ghana (Revised Edition*) and include a new section 42 (g) of the Criminal Offences Act which removes the marital rape exemption with a parenthetical note stating that the exemption was unconstitutional. Archampong & Sampson (2010, p.510) question whether the Parliament actually realised that by approving the revised laws it had undermined the marital rape exemption in section 42 (g) claiming it as significant because that 'same Parliament had earlier rejected definitions of sexual abuse in the draft domestic violence bill which effectively sought to repeal section 42 (g) of the Criminal Code'.

The progress towards equality for Ghanaian women in legal terms is certainly positive. However, section 42 (g) of the Criminal Offences Act still does not support women against marital rape because it leaves them 'vulnerable to the presumption that they have consented to marital sex *unless they can somehow prove they revoked their consent prior to the sexual attack in question'* (Archampong & Sampson 2010, p.510).[102] This burden of proof was described by participants I spoke to in the village and was one clear reason for them not to legally challenge a sexually aggressive husband. As Archampong and Sampson (2010, p.510) argue 'judges may interpret revocation of consent in a way that would make it difficult for a married woman to prove'. The participants of this study certainly did not know how they could provide such proof. The current Act still disadvantages women and leaves them without protection from the law.

Obviously the discourses of a holistic sexuality deemed appropriate at the level of the body politic are provided to fulfil global political aims and expectations. However, the

[102] My Emphasis.

sincerity of commitment to the humanitarian notions of equality and empowerment for women is contradicted by Ghanaian national law which, in practical terms, still does not hold husbands criminally responsible for committing rape against their wife. Despite Ghana's Reproductive Health Strategic Plan recognising the relevance of complete physical, mental and social well-being for general health, and proclaiming the importance of a safe sex life free from violence or coercion, national legislation does not in any active way provide for the criminalisation of marital rape.

The Conflation of National Law and Traditional Belief Structures: The Real Discourse of Female Sexuality

The reason for the contradiction of national legislation with the humanitarian ideals of the global political order rests in the conflation of traditional belief structures and the national law. Many of the individuals who are opposed to a law against marital rape argue that such a law is in contradiction to Ghanaian culture. Very prominent figures in Ghana have voiced their views on the matter. Edward Mahama, a medical practitioner and presidential candidate of the People's National Convention (PNC) party argued that 'If we talk about marital rape, it means we are going into the bedroom, and we have no right to go there….you cannot legislate on such issues' (Archampong & Sampson 2010, p.511). Indeed many prominent people in Ghana described the criminalisation of marital rape as 'anti-Ghanaian' (ibid). Even Gladys Asmah, the first minister to head the Ministry of Women and Children's Affairs, established in 2000, is in opposition to the criminalisation of marital rape within Ghanaian national law. She is reported as stating that:

'They want me to confront the men, but that is wrong. Do you know what will happen if women start accusing their husbands of rape and start taking them to court? It will destroy marriages and more children will be thrown on the streets. I will not encourage a law that will destroy marriages'.[103]

Despite the Ghana Reproductive Health Strategic Plan espousing a political commitment to women's sexual security and empowerment, the reality is legalised patriarchy and the maintenance of structural violence against women. Indeed, an

[103] Safo, Amos (2005) 'Ghana: Minister Throws Last Punch', *Public Agenda* (21 January 2005).

attempt to criminalise marital rape was seen as such a challenge to the established social order that it was described as 'un-Ghanaian' or 'not in the character of the nation'. This is a situation of real ambivalence. The global political discourse advocates sexual restraint and equality as a way to achieve health and development goals and thus the stability of the nation, yet at the level of national politics the imagined community is one where male sexual control is paramount and the well-being of women of secondary importance to the well-being of children and the institution of marriage. Marital rape is overlooked and the asymmetry of sexual power relations deemed as cultural. Farmer (2003, p.xiii) argues that 'human rights violations are not accidents. They are symptoms of deeper pathologies of power that are linked intimately to social conditions that so often determine who will suffer abuse and who will be shielded from harm'. Despite attempts to integrate a mode of sexuality which recognises women's human rights, the current situation in Ghana is that the mode of sexuality expressed at the level of customary law is supported by national legislation, and it dominates patterns of social relations.

The real discourse of sexuality inscribed on the bodies of Ghanaian women at the level of the national body politic is therefore one of subordination and sacrifice, as it is in traditional customary law. The Ewe are not the only tribe in Ghana who believe that female members of society are subordinate to males. This is a common understanding within Ghanaian society as a whole. These beliefs are deeply embedded in forms of cultural practice which serve to produce and reproduce women's inequality as a systemic cultural reality. A powerful example of the notion of female sacrifice can be found in the now out-lawed cultural practice of *trokosi*, among the Ewe people of the Volta Region.[104] This religious practice involved families sending their virgin daughters to live and serve at the shrine of priests of the traditional religion. This was a form of sexual servitude for the girls as reparation for the crimes committed by other members of their families. This practice is now a subject of embarrassment for some Ewe and so I use the example somewhat reluctantly to illustrate two points. Firstly, that the idea of a woman 'giving her body'

[104] The Trokosi was practiced in the area of this study in the past. Lithur (2004) argues that despite the legislative change there has not been a reduction in the number of girls being held in bondage at shrines in Ghana (p.73). However, I was informed that the practice had stopped in the Abladzo area and I consider my sources reliable in this matter. I also spent time at the local shrines and attended ceremonies and funerals and I saw no evidence of such a practice currently.

is deeply ingrained in the collective consciousness of Ghanaians. In the *trokosi* practice a woman 'gave' her body as a way to provide atonement for the ill deeds of others. She could not refuse. The sexual provision of her body for use by the shrine leader was articulated within a religious context of need or necessity. Thus her body was sacrificed for the needs of others.

This idea of need transfers itself also to popular social practice whereby some women use a mixture of ginger and other hot spices made into a ball and inserted into the vagina to cure pain. Anarfi (1996, p.10) claims that 'the main reason for women to do this is to maintain good health and to be able to provide for the husband's sexual needs always'. The sexual subordination of women to the 'needs' of others is very much part of the cultural schema of Ghana. However, the *trokosi* was successfully out-lawed and is now seen by most as a negative cultural practice which was abusive to women.[105] [106] This demonstrates that more recent arguments which call on cultural relativity to oppose the criminalisation of marital rape are largely self-serving and unjustified in the light of international human rights frameworks. Cultural practice and traditions can, and do change.[107] It also gives hope that Ghanaian women in need are not beyond more thorough legislative protection in the near future.

[105] Locally, the term 'unfair to women' is used to describe the trokosi rather than 'abusive'.

[106] While almost everyone I spoke to in Ghana believed that it was a positive step to outlaw the *trokosi* practice, I met one very elderly woman in the village who did not believe the *trokosi* was abusive to women. She had been married to the shrine leader and told me that she was very proud of her life and the traditional religion, and that her social position in the shrine had been one of high cultural and spiritual capital. She was very kind and polite to me but she expressed strong resentment of white people changing African cultural practice.

[107] For examples of traditional rules and social praxis being adapted to suit a changing social and political environment in a rural village in the Volta Region See Tsey (2011, p. 79). Tsey (2011) provides case study examples of Ewe people living in the village of Botoku in the Volta Region having made significant adaptations to traditional rules and values as they deemed the changes necessary. He gives the examples of a decision in the 1970s to make citizen participation in community development projects a condition for the chiefs and elders performing funeral rituals on ancestral land; a 1960s decision not to allow dogs on Botoku land because of a threat of a rabies epidemic and a decision in the 1970s to outlaw *akanyiyi* (trial by ordeal) in the case of witchcraft and other sorcery accusations (2011, pp.79-97).

Chapter Twelve

The Social Relations of Sickness

Part three of this thesis has discussed the ideas that dual discourses and social inequalities inherent in the politics of health in Ghana actually prevent global and national healthcare endeavours from effectively aiding women in need in the village of Abladzo. The following chapter returns the anthropological gaze to circumstances at the village. It examines the ill-health outcomes for some women which have emerged as an aspect of national and international failure to adequately acknowledge and address social circumstances of gender inequality in Ghana. The combination of political inefficacy, patterns of sexual social relations in the village, and the introduction of biomedical healthcare solutions has resulted in the medicalization of some women's social needs in the rural village.

Gender Relations and Social Distress

The majority of studies about family planning or unsafe abortion in Ghana fail to discuss the issue of violence and coercive sexual relations which confront some women and lead to unwanted pregnancy (Bleek 1976, Ampofo 1994, Anarfi 1996, Bhatia & Newmann 1982, Ahiadeke 2001, Geelhoed et al 2002, Kodzi et al 2012).[108] [109] For the participants of this study involuntary sexual intercourse was a very significant part of their sexual experience and a major reason for a distressing lack of control over reproduction which frequently led to self-induced abortion. However,

[108] Bleek et al (1986) mention inequalities in the sexual relationships between female High school students and their teachers. In general, few studies examine violence as a contextual risk factor leading to unwanted pregnancy. In a study of Gender-based violence as a risk factor for adverse reproductive health Gomez & Speizer (2010) state that few studies examine the relationship that exists between gender-based violence and unintended pregnancy. In a study among young women of five African countries Gomez & Speizer (2010) conclude that gender-based intimate partner violence can inhibit young women's ability to engage in safe sexual behaviours due to a lack of control over sexual encounters. For further reading about the link between partner violence and gynaecologic morbidity and unintended pregnancy see: Cripe et al (2008), Pallittto & O'Campo (2004) and Silverman et al (2007).

[109] This is somewhat puzzling because violence against women is to a significant extent accepted by both sexes in Ghana (Glover et al 2003). This may lead to an under-reporting of sexual coercion as a reason for unsafe abortion as it is not identified as a factor of relevance by research participants. This under-reporting may also be supported by methodological avenues chosen by researchers. Of course it is also possible that in some studies experiences of coercion were not a factor in the lives of research participants who performed unsafe abortions. While it is beyond the scope of this study, an investigation into this issue would be a very valuable contribution to the current literature.

current family planning programmes do not appear to address this social distress. Even while I was undertaking this study, there was a medical volunteer doing a study of family planning in Abladzo village. The research involved a yes/ no questionnaire about how often women used family planning and what methods they preferred. The researcher, a fifth-year medical student, returned to his country of origin unaware of the violence endured by village women or of the fact that many of them induce abortions at home to deal with unwanted pregnancies. This was largely not his fault. He is trained in the medical sciences and the research about family planning was approached from a bio-medical perspective.[110] However, the fact that abortion is approached officially as a 'health issue' and therefore presumed to be largely within the domain of bio-medicine may be a major barrier to truly providing assistance to those in need.

The importance of analysis of social factors relating to problems defined as 'health' issues is made clear by Avotri & Walters' (2001) study of the health of Ghanaian women, which was also undertaken in the Volta Region. According to the article, the women understood health in social terms as something that was inseparable from their roles in social production and reproduction. In particular, the women were concerned about the way in which their (ill) health was shaped by gender and their relationships with men (Avotri & Walters 2001, p.199). The women in the study describe their ill-health as being caused by insecurity and a lack of control over their lives. They cited the institution of marriage as being a central problem because it defined a role and responsibilities as a wife, which were too burdensome. Furthermore, it placed the women in a subordinate position to the husband which often meant they had to endure physical and verbal abuse (Avotri & Walters 2001, p.199). Interestingly, some participants from the Abladzo village also expressed their health concerns in social terms. Quite specifically, when asked to describe the key health concerns for women in the area, one participant replied in the following way:

W: *The main health issue in the area is between men and women. Sometimes some of the women feel that they are ripe enough [sic] to have a child but the men are not*

[110] I also consider the fact that he (and his translator) are male and therefore local women may not have communicated so openly with him.

ready at that time. And sometimes the men are ready for more babies but the women are not ready at that time. So that is the main issue here.

Me: *Do you think it is easy to communicate and make that balance?*

W: *If there was good communication between husband and wife that would put a stop to it.*

Me: *But generally is there good communication?*

W: *No*

Me: *Why not?*

W: *Right now my child is only two years and I knows the child is still young but there are men who are like goats…like he goats….they will like sex every time so if you marry such a man, he will be harassing you for sex all the time and after the sex then what follows is a pregnancy.*

In addition, every other woman interviewed, described women's health problems as 'abdominal pain', 'bleeding' or 'problems with relationships with men'. In fact, at the community clinic, there are large numbers of people, men and women, who come to seek treatment for malaria or farming injuries. However, none of the women saw these as the major health issues for women in the area. The perception of women's health problems was clearly linked with patterns of social relations. This leads me to question the appropriateness of simply providing oxytocin injections for women at the Abladzo medical clinic, without addressing the social issues which create the need for those injections in the first instance. To continue to do so is to medicalize social distress. Those in charge of the Abladzo community clinic are largely aware of this issue and are currently somewhat unsure about how to proceed because addressing the problem means questioning some very serious, deeply embedded social practices. This is a political tightrope for the international stakeholders who established the clinic. There are the obvious human rights issues related to self-induced abortion in

the area, but there is also the threat of accusations of neo-colonialism if the clinic is seen to be attempting to change facets of culture which are systemic.

The Medicalization of Social Suffering

The medicalization of the social distress of some village women occurs in the wider health system also, not just the clinic. After talking with me about her attempts at self-induced abortion, Lucia, a local woman, sat back in her chair under the trees and looked pensively across at myself and a Spanish mid-wife who was volunteering at the clinic. I had asked the Spanish volunteer, Maria, if she would join me because she was a qualified rape counsellor and nurse with a background in family planning. At the end of the interview, the woman asked if she could speak to Maria and she described her concern about the side effects of some contraceptives but also about her bleeding.

W: *The Depo [Depo-Provera] has so many side effects. People take it and they grow lean. People take it and they grow fat….people take it and they have their menses two or three times in a month. That is why I want the implant. I am still bleeding now so… can Maria examine me?*

M: *When did you do the abortion?*

L: *One year [ago] now*

Me: *Have you been bleeding continuously for one year?*

L: *Yes, any time I have my menses*

Me: *…and you keep bleeding? [surprised and concerned]*

M: *For how long?*

L: *Three weeks until I take the injection*

M: *So you did the abortion one year ago and you haven't done family planning since and every month you spend three weeks bleeding and one week without bleeding.*

L: *Yes, unless I come to the clinic for an injection.*

M: *Yeah, but this injection is [only] a remedy for this very bleeding there is a problem there. If you come here and get the injection… ok the bleeding will stop, but the month after it will start again so that is not the solution.*

L: *I know…..*

M: *You need to get checked and that needs to be done in the hospital.*

L: *Anytime I put my hand to my vagina the cervix is opened [she is very concerned]*.

M: *I could examine you…if you want. I could examine you here and see what is wrong but probably you will still need to go to the hospital because this doesn't look good at all.*

L: *I was in the hospital in Accra and I was told I had a fibroid. So right now… I think it is the fibroid that is pushing the blood out. It is too burdensome.*

M: *Yeah, it can be but normally if there is this problem it is good to use the pill – even though you had problems with the pill in the past; it is good to use the pill to regulate the bleeding.*

L: *I have no pill [she is implying also that she does not want the pill]*

M: *I know you don't have a pill… and when you were diagnosed with the fibroid, did they give you any treatment for that?*

L: *They only stopped the bleeding*

M: *For that very moment?*

L: *Yes, for that very moment*

M: *…and that was in Accra?*

L: *Yeah.*

Firstly, Lucia was very concerned about the health impacts of using strong medicine such as Depo-Provera. Many of the village women had told me the same thing while I was living at the clinic.[111] They did not like the side-effects from the medicine and were worried about taking it long-term. In fact, Lucia was just 21 years old. She had been married for a little under two years and she was training to become a seamstress. She had explained how she was unable to refuse her husband's sexual demands and had experienced sexual intercourse by force many times. She was not always able to afford contraceptive medicine and so she had performed self-induced abortions with the *babati te* plant three times because of these life circumstances. She told me that she was 'saving up' for the implants because she worried about the side-effects of the Depo-Provera and her husband did not permit her to take the pill. The implants could be 'kept a secret'.

The fact that she had been to the hospital and was diagnosed with a fibroid but had not been given any real treatment or advice is concerning to say the least. Lucia was simply given oxytocin and sent away. The Abladzo community is an example of social actors who are recently incorporated into the biomedical healthcare system becoming prey to the medicalization of their needs (Scheper-Hughes 1992, p.169). Scheper-Hughes' (1992, p.169) work on the folk idiom of Nervos describes the way in which a social problem such as starvation is 'appropriated and transformed into something else: a biomedical disease that conceals the social relations of sickness'. Currently, the social inequalities experienced by some village women in Abladzo are being appropriated and transformed into purely personal 'medical problems' to be resolved by bio-medical treatment regimes. I argue that the fibroids, severe abdominal

[111] Such conversations with locals occurred as villagers often came for social visits to the clinic compound area and liked to engage in translated interactions with the international volunteers. I engaged in many such interactions with locals who would talk quite freely about many things.

pains and excessive bleeding experienced by many women in the Abladzo village may be a kind of bodily protest against the culturally permitted sexual subordination they must endure in their daily lives. Kleinman (1995) details the way in which social suffering expresses as a somatic experience of bodily symptoms, particularly when there are no other external avenues for release of that pain. This is what Scheper-Hughes (1992, p.214) calls the 'language of the organs'. She argues that 'we cannot forget that whatever else illness is …it is also an act of refusal, an oblique form of protest…the person assuming the sick role says 'I will not, I simply cannot any longer'(Scheper-Hughes 1992, p.214).

Limited in agency by the gender expectations of the local Ewe culture, many of the women of Abladzo do not have much opportunity to voice the discomfort and distress they feel in their relationships with men. Their protests are often met with beatings, abandonment or verbal abuse. One participant explained:

M: *Women can't say much. That's because in our country they say that a man is a head of the family. So you the women, you don't need to say anything...whether he is wrong or not...you don't need to say anything.*[112]

Me*: And it's like that here in the village?*

M: *Yeah. Strongly...in every way.*

Sickness can be a passive resistance to the social and moral order of the community. Scheper-Hughes (1992, p.187) argues that socio-economic and political contradictions often take shape in the 'natural contradictions' of sick and afflicted bodies. Sickness therefore becomes a way of expressing the real state of things which cannot be spoken. Ofei-Aboagye (1994) writes of the lack of acknowledgment of the extent of violence against women in Ghanaian society. I do not believe that it is coincidental that in a community where women are frequently raped, the health issues cited as most problematic and common are all gynaecological. The women cannot accuse the

[112] Ezeh (1993, p.170) also discusses the difficulties some Ewe women face in trying to discuss issues with their husbands. A young woman in her study claimed that '*they [men] do not regard ideas from women. They will not sit down for a discussion, let alone listen. They prefer ideas from their fellow men'.*

men of rape or abuse as the popular interpretations of such acts within customary law are simply marital entitlement and discipline. Likewise, within national law, it is impossible for the women to prove an incident of rape. The expression of severe distress is therefore only available to the women via the somatic idiom of gynaecological disorder.

A Woman's Burden?

Scheper-Hughes (1992, p.187) employs the idea of a generative metaphor which describes an illness and links it to wider social conditions. A fibroid, as a mass of inflamed extra bodily tissue located in or near the uterus, could also be described as a lump or, as stated by the participant, 'a burden'. Here I wish to use this concept of a 'burden' as a generative metaphor for illness experienced by some of the women who live in and round Abladzo village. The word 'burden' was used frequently to describe women's life experiences in the village both by the women themselves and by others, and there were a number of local women who told me about having experienced fibroids.[113] The dictionary meaning of burden is 'an oppressive load and wearying'. In addition, the origin of the word burden in old English has two meanings, but the older meaning which is 'load' comes from the old English '*byrthen*' meaning bear or birth. This links to an older Indo-European base '*oher*' which signified both 'carry' and 'give birth'. The later meanings of 'burden' became 'responsibility' in the sense of 'one's burden to bear' (Ayto 2005, p.83). The social load or burden carried by the women of Abladzo is enormous: physically, financially and emotionally as has been described in this study. It is possible that through the expression of a fibroid, the participant is protesting any additional burden or load she is expected to carry. It is particularly worth considering the word's original meaning of 'give birth', within the context of the life of a woman who does not want additional pregnancies and the subsequent social responsibilities pregnancy entails. However, in many respects these women have few choices. Indeed, the greatest ontological security for some of these women against the burden or responsibility of an unwanted pregnancy is the use of the potentially fatal plant *babati te.* It is a sad irony that the toxicity of *babati te* has

[113] The idea that fibroids are a health complaint commonly experienced by many local people is supported by data from the local District Assembly Health Department which cites fibroids as the second most common cause of in-patient morbidity in 2008. Annual Healthcare Report Ewe District Health Department (2009-2010, p.40).

become the chief remedy against the toxic social reality of sexual inequality endured by some local women.

It is culturally inappropriate in many matters for the rural Ewe women in this region to 'speak against men' as described by the participant above, so it is not surprising that the gender relations which create 'dis-ease' are expressed in individual female bodies as gynaecological 'sickness'. Scheper-Hughes (1992, p.174) states that 'a sick body implicates no one. Such is the special privilege of sickness as a neutral social role; its exemptive status'. I believe that this is the case for some of the women who live in Abladzo. Having a sickness means that they can express bodily complaints and seek help or a remedy to their situation within a neutral social category. They do not need to confront men. If health workers who are confronted with these women's bodily complaints see them only as biological 'health' issues or simply bodies in need of family planning, then they 'fail to see or misidentify the secret indignation of the sick poor' expressed in an idiom of gynaecological distress (Hopper 1982).[114] They will also consequently fail to assist these women, and fail to provide real well-being. Moreover, they will have denied a collective experience of sexual distress and transformed it into a personal disorder which requires medicalization. In these circumstances, the notion of 'bad faith' can be applied to state health services who merely offer injections and a variety of family planning methods and, worse still, scold women for a lack of bio-medical compliance. Moreover, if the women who suffer do not ' recognise the language of protest expressed by their bodies' as fibroids and abdominal pain and they 'silence it or surrender more consciousness and pain to the technical domain of bio-medicine, the opportunity for transformation may be lost' (Scheper-Hughes 1992, p.214). Scheper-Hughes (1992, p.214) argues that 'once safely medicated the scream of protest is silenced [and] fear and violence domesticated and socialised [ensure that] the social origin of women's pain [is] hidden and concealed' [sic]. Currently, political discourses on family planning and 'health' are promoted in Ghana at the expense of addressing a more radical discourse on gender relations where a greater level of well-being for women could be made manifest.

[114] The phrase 'fail to see or misidentify the secret indignation of the sick poor' was expressed by Hopper (1982) and cited in Scheper-Hughes and Lock (1987, p.27) 'The Mindful Body'. Hopper's concern was that too often healthcare workers are predisposed by their medical training to disregard possible social origins for health complaints.

Chapter Thirteen

Development and Gender Interests

In the introduction of this work, it was explained that the aim was to explore both why women in Abladzo were performing self-induced abortions, and to assess the degree to which the community clinic is able to empower women. It is hoped that it is now clear to the reader why some women persist with self-induced abortion. However, the second aspect of the research, the way in which local women are empowered by the presence of the community clinic, has been given less thorough treatment. The issue of medicalization, which was discussed in chapter ten, is an important aspect of the immediate outcomes of the current set of social circumstances which are interwoven with the issue of self-induced abortion in this rural area. This chapter is an examination of the involvement of the NGO presence but looking beyond the issue of medicalization to a broader developmental perspective. This perspective offers theoretical insight into the degree to which the community clinic impacts the lives of women who undergo self-induced abortion, as well as insight into the valuable distinctions which must be made between current levels of support for the women and possible avenues of future empowerment.

The work of Molyneux (1985) is frequently used in feminist literature to deploy criteria to assess the degree to which gender interests are expressed in a given social situation. Her work offers two categories which are salient to the issue of self-induced abortion in Abladzo. The first category is termed Practical Gender Interests (PGI) and refers to the concrete conditions of women's positioning within the gender division of labour. The interests are usually formulated by the women themselves within these positions and are a response to an immediate perceived need. However PGI do not usually entail a strategic goal such as emancipation or gender equality. Moreover, PGIs do not in themselves challenge the prevailing forms of gender subordination despite arising directly from them (Molyneux 1985, p.233). The second category is termed Strategic Gender Interests (SGI) and these are primarily 'derived from the analysis of women's subordination and the formulation of an alternative, more satisfactory set of arrangements to those which [currently] exist' (Molyneux 1985, p.233). SGI consist of a set of often external, ethical and strategic objectives to

overcome women's subordination. Molyneux (1985, p.233) cites the abolition of the sexual division of labour and the establishment of free choice of childbearing or the adoption of adequate measures against male violence as examples of demands formulated within the category of SGI.

With regard to the circumstances of women who attempt self-induced abortion in and around the village of Abladzo, there is in fact some overlap of these categories although ultimately, the provision of oxytocin injections by Ghana KINDNESS NGO must effectively be considered as serving women's PGI rather than impacting on SGI in any significant way. This evaluation of the contribution of the NGO to the women's well-being should not be taken as a negative critique of its efforts. On the contrary, the provision of social and medical assistance is quite literally saving women's lives in the local area. The participants of this study also stated quite clearly that because of the presence of the community clinic they feel that they have more personal control over their body than they have ever felt in their lives. This increased feeling of bodily control and ontological security has been brought about by the activities of Ghana KINDNESS fieldworkers in collaboration with local people. However, a realistic appraisal of the provision of oxytocin injections and contraception reveals that such actions do not address local women's SGI. The provision of medical assistance at the time of crisis does not contribute to a tangible recognition of greater gender equality or women's SGI. Short-term, such interventions have significant value. However, if medical crisis interventions become entrenched aspects of community life, there is a very real risk of the NGO inadvertently assisting to maintain patterns of women's oppression. The unintended consequence of medical aid would in fact be the chronic medicalization of social distress and gender inequality as described in the previous chapter. For Molyneux (1985) principles of gender equality can only be realised within determinate conditions of existence. The limits of cross-cultural solidarity on such matters can be seen quite clearly as intricately woven into the social fabric of existence. In this respect, there is a limit to the extent to which Ghana KINDNESS as an NGO can push the boundaries of local Ewe cultural practice in their efforts to empower local women.

However, for Sen (1999, xii), overcoming such limits is the central part of the development paradigm. While he recognises that individual agency is inescapably

qualified and constrained by social, political and economic opportunities, he also argues that the expansion of freedom is the primary end and the principle means of development. He argues that to counter problems, we have to see individual freedom as a social commitment and that development involves removing the various types of 'unfreedoms' that leave people with little choice for exercising reasoned agency and living lives they value (Sen 1999, xii). Sen's (1999) focus on lived human freedoms is a powerful argument against an overemphasis on technical solutions such as family planning, at the expense of a commitment to changing other influences which create systemic social deprivation. Both Molyneux's (1985) categories of gender interests and Sen's (1999) evaluative reasoning provide ways to assess the impact of family planning solutions for the women of Abladzo. Unfortunately the assessment reveals little real change. Sen (1999, p.3) argues that progress has to be measured in terms of 'whether the freedoms that people have are enhanced'. For the participants in this study who are still forced to perform unsafe abortions, it cannot be argued that freedom has been offered them; survival mechanisms yes, but not freedom to achieve the alternative life choices that they desire. The need for the women of Abladzo who desire so to be offered a greater sense of agency is in Sen's (1999) terms a 'constitutive' part of development because it contributes to the strengthening of other kinds of free agencies and thus advances the general capabilities of a person and the development of the community as a whole. In many respects the current framework of a medicalized form of support for women is creating a dependency on aid. From my experiences in Ghana, I feel confident to argue that dependency on aid is the very last thing that Ghana needs or Ghanaians want.

In accordance with the findings in this study, Sen (1999, p.17) argues that 'inequality between men and women severely restricts the substantive freedoms that women enjoy', and that 'tradition and cultural heritage frequently play a role in women's oppression'. He also addresses arguments that cite development as harmful for a nation in the sense that it may lead to the elimination of traditions. This was a fear expressed by Ghanaian political leaders in chapter nine, who claimed that an examination and reform of the Domestic Violence Bill and the Criminalisation of marital rape would be 'unGhanaian' or 'not in the character of the nation'. Nonetheless, Sen (1999, p.31) poses the question of 'what to do when it turns out that some parts of tradition cannot be maintained along with economic or social changes

that may be needed for other reasons?'. This question is central to the qualitative findings of this thesis. The social practices associated with the sexual subordination of women, to the point where it is harmful to their physical and psychological well-being, cannot be maintained. Moreover, the importance of women's health notwithstanding, the nation of Ghana simply does not have the financial resources to medicalize this social problem in the long-term. It must deal with the root causes. The fact that in some cases very oppressive behaviour is justified in light of tradition must be addressed. Here the work of Tsey (2011) is instructive. Tsey (2011, p.79) argues that development is not only about technical solutions or physical infrastructure but about the 'customs and traditions that guide social interactions between people...'. He states that while customs and traditions 'create order and stability and community cohesion', these same traditions 'can quite ironically undermine the dignity and well-being of people, especially the vulnerable sections of the community, if approached or applied uncritically' (Tsey 2011, p.79). Accordingly, Tsey (2011, p.97) states that 'any meaningful effort to promote development among more traditionally orientated societies experiencing social change such as Ghana…ought to focus on creating safe spaces for respectful but *critical* public deliberation or conversations among communities of people with regard to the extent which their customs and traditions promote or undermine their search for a better future [for all members of the community]'.[115] The fact that Tsey (2011) is himself a Ghanaian and an Ewe born in the Volta Region near where this research was undertaken, gives powerful credibility to my argument that patterns of gender inequality leading to unsafe abortion in this area must be acknowledged, critically examined and changed for the well-being and development of local women but also the community as a whole.

While many arguments are centred on the elimination or preservation of tradition this should not lead to fears of dichotomised notions of elimination or preservation of culture in totality. Tsey (2011, p.79) suggests that the goal of critical conversations about tradition is to identify those [traditional beliefs] in need of being dismissed' but also to 'identify aspects relevant to the challenges and opportunities of contemporary living conditions, and hence worth preserving'. In-depth discussions with local people in and around Abladzo reveal that an appropriate course of action may be to

[115] My emphasis

emphasise and facilitate social praxis which reinforces the higher values already present in local Ewe culture and tradition. Conversations with elder Ewe in the village area, both men and women, revealed a tradition filled with concepts of love, patience, compassion, kindness and forgiveness. It seems likely that in the hardship of life, particularly in an economic sense as discussed in chapter four, the higher virtues of tradition have gradually escaped some local people. Noteworthy is the statement made by the elder who told me that 'a husband is supposed to be fair to his wife'. In consideration of the post-colonial political context within which these unequal sexual social relations take place, an appeal to these higher human cultural virtues may be a good place to initiate the process of change towards greater gender equality and thus reduce the instances where local women feel compelled to perform unsafe abortions.

Of interest also is the fact that both Sen (1999) and Molyneux (1985) cite the relationship between policy and public participation. For Molyneux (1985) the way in which gender interests are incorporated into wider strategies of development has real bearing on practical outcomes for women. She suggests that typically gender interests can be articulated into development strategies or they can be subordinated to them. In the first case of gender interests being articulated into strategies for development Molyneux (1985, p.251) argues that gender interests would be 'recognised as being specific and irreducible and requiring something more for their realisation than is generally provided for in the pursuit of the wider [development] goals'. As discussed at the beginning of this thesis, the 1994 ICPD was a significant step in truly articulating women's interests into practical strategies for development. Accordingly, Molyneux (1985, p.251) claims that when women's gender interests are articulated into development issues, even when the pursuit of a full program for women's emancipation cannot be attained for various reasons, the situation can be explained and debated. Thus 'the goal is left on the agenda and advances can be made within the existing constraints' (Molyneux 1985, p.251). In accordance with Molyneux's (1985) ideas, the 1995 Fourth World Conference on Women was subsequently able to ensure that the commitments made at the 1994 ICPD were expanded and legislative goals which had been previously neglected by national governments were pressed forward and achieved. Such achievements occurred because of the inclusion of a broad range of voices such as women's rights advocates, government allies, religious leaders and NGOs. These groups were able to articulate specific programme goals for the interests

of women as an integral aspect of development. However, in Molyneux's second case the specificity of gender interests is likely to be denied or its overall importance minimised. She cites the way in which in this case the program for women's equality remains conceived of in terms of how functional it is for achieving the wider developmental goals of the state (Molyneux 1985, p.251). The issue of unsafe abortion in the village of Abladzo can be placed within Molyneux's (1985) second case as it is directly related to the compromised policy trajectory of the MDGs.

The Millennium Development Goal number three represents a lack of political will to sincerely respond to women's greatest needs. The goal's almost singular focus on education as the means of promoting gender equality has left a vacuum where concrete and practical action about women's sexual and reproductive rights need to be. The MDG number three has allowed the Ghanaian state to formulate gender interest policy on *what* interests are represented in the state, and simultaneously avoid addressing more critical gender interests. Moreover, women's sexual and reproductive rights have been further minimized and buried within MDG number five of promoting maternal health. Discussion concerning the social issues relating to women's self-determination of their reproductive needs is stifled by the presence of technical solutions. In the case of Abladzo, medical and technical solutions certainly do not stop some women's suffering, although such solutions do seem to alleviate the state's political gender interest obligations in a bureaucratic sense. The second chapter of this thesis showed the way in which discussion of these issues has been retarded by ceding to conservatism within the international political climate. This is a problem of very real significance. Sen (1999, p.226) argues that what is taken to be 'standard behaviour is not independent of the understanding and appreciation of the nature of the problem'. He states that 'public discussion can make a big difference' (Sen 1999, p.226). However, debate about women's SGI in the context of their sexual and reproductive rights was stifled by the exclusion of wider interest groups in the formulation of the MDGs. Molyneux (1985) argues that in unfortunate cases women's development goals are framed in policy according to how functional they are for achieving the wider goals of the state. With regard to MGD number three, it is unfortunate that this time women's development goals were formulated, framed and ultimately diminished in policy with regard to how functional they are for achieving wider 'global' goals. Indeed, women's SGI are an integral aspect of their health needs

and would likely be best served by returning to specific discussions of women's reproductive rights and formulating specific courses of action to ensure such rights are recognised and protected. Accordingly, adequate outcomes with regard to women's SGI in Abladzo village cannot be achieved by an NGO alone or by the women themselves, but, in Sen's (1999, p.xii) terms, require multiple stakeholders to make a sincere and solid 'social commitment to the expansion of freedom as the primary end and principle means to development'.

Chapter Fourteen

Conclusion

Unsafe abortion is a very serious health concern for Africa and is largely unmitigated by current programs of action, both national and international. In rural Ghana incidences of unsafe abortion remain unacceptably high. This analysis of self-induced abortion in the rural village of Abladzo has been an attempt to understand why some local women perform this dangerous social practice. The answer in short, is because performing an unsafe abortion with the *babati te* plant is sometimes a woman's best means of resisting reproduction. The title of this thesis was chosen for its double meaning. 'Resisting reproduction' can be seen as the women exercising agency via an unsafe abortion and thus preventing a birth in a biological sense. On the other hand, the meaning of ' Resisting Reproduction' can also be seen through the anthropological gaze as the women 'resisting reproduction' of the vast array of cultural norms, values, expectations and social practices placed on them by the structuring components of the local Ewe society to which they belong. In many respects the findings of this thesis also reflect these two ways of perceiving the idea of resisting reproduction – the biological and the social. I have argued that continued incidence of unsafe abortion in the rural village of Abladzo is very much more than 'an unmet need for contraception'. The idea that the intensification of family planning programmes and technical service provision alone will transform women's health outcomes in the rural Ewe village is at best ill-informed. These are reductionist ideas viewed through a predominantly biomedical lens. The causes of unsafe abortion and some women's negative health outcomes in the village are predominately social. Furthermore, the solutions to the problem of high incidence of unsafe abortion in rural Ghana are also located largely within the social world. This of course does not mean the exclusion of medical and technical services, but that sufficient attention must be given also to issues of gender equality.

In Setting the Context, the second chapter of this thesis, I argued that the International Conference on Population and Development (ICPD) and the Fourth World Conference on Women made significant advances for women's health. The

conferences brought attention to the considerable rates of morbidity and mortality suffered by women in the developing world who undertake self-induced abortions. At these key international conferences both the biological and social issues relating to unsafe abortion were placed on the agenda. A human-rights based discourse about women's reproductive security and their right to say 'No' to unwanted and unprotected sexual relations also formed part of the discussions. However, the limits to advances in women's gender interests were made clear by the compromised policy trajectory of the Millennium Development Goals (MDG). The decision to bury the issue of specifically addressing women's reproductive rights was made because such an issue was simply too contentious in the global political community and threatened to undermine the cohesiveness of a united global approach to development.

Regardless of potential arguments about the necessity of accepting the currently conservative global position on women's reproductive rights, the outcome with regard to the issue of unsafe abortion in rural Ghana is clear. The opportunity for commitment to women's reproductive rights as an important goal for 'gender equality and women's empowerment' in MGG number three has now passed. It has been reduced to a more politically acceptable response to the issue of women's sexual and reproductive health. This is the MDG number five which addresses 'maternal' health. This focus reinforces the acceptability of women's sexuality as being primarily within the context of childbirth and diverts discussion from issues of women's sexual and reproductive self-determination. The advances made in the area of unsafe abortion in Ghana have therefore been achieved through MGD number five and have focused on medical and technical service provision and the promotion of 'family planning' options in accordance with WHO guidelines. While these advances are certainly relevant and useful to those who can access them, they provide no real assistance to some of the rural women in need in Abladzo.

In chapter five, I began the ethnographic accounts of the thesis from Scheper-Hughes' & Lock's (1987) idea of a personal body. Their notion of a 'phenomenological experience of embodiment' or the idea of a 'lived body-self' allowed me to introduce the reader to the local women's primary method of inducing an abortion with the toxic local plant called *babati te.* The chapter also informed the reader that this plant is potentially fatal for the user. Nonetheless, the social practice of self-induced abortion

using the *babati te* plant is described by participants as necessary for some local women who do not wish to give birth. This is particularly so for women who have only recently given birth and who have become pregnant again. Many local women fear that they simply cannot do heavy manual labour on the farms, carry loads, complete their arduous household tasks and bear multiple children without giving their bodies rest. This fear is well-founded according to Unnithan-Kumar (2008, p.404) who describes childbearing in developing countries as a 'physically debilitating and unsafe period', especially in the lives of rural poor women. *Babati te* was described as a way of spacing births and a way out of the constraints of the extreme physical demands placed on a woman's body during pregnancy in the rural Ewe community. Under such physically demanding life conditions, self-induced abortion is a women's way of resisting a pregnancy which potentially threatens her own life. Through the use of *babati te,* some women actively choose to take control of their bodies and life circumstances as best they can.

In chapter six I employed Scheper-Hughes' and Lock's (1985, p.6) concept of 'the social body' as a way for the reader to conceptualise the sociality of a woman's body in a rural Ewe community. I attempted to demonstrate that a woman's body was not simply her own to do with as she pleased, rather, it is a kind of social interface which is integral to the production and reproduction of multiple kinds of relationships with other social actors, but also among nature, society and Ewe culture. I demonstrated that some local women are unable to use contraceptive methods because these are forbidden by their husbands or male partners who prefer large families. I turned to a Marxist analysis of the local economic mode of production to show how some village women experience the dispossession of their bodies through involuntary child bearing and raising. The necessity of multiple children to provide labour on the farms makes a woman's reproductive capacity central to subsistence survival but also to attainment of forms of wealth and security. I demonstrated the fact that the relations of production in the self-sustaining agricultural community of Abladzo are based on household- unit kinship relations. In this respect the relations of production are entered into independently of the will of many local women. Many women must farm as it is their main means of economic survival. The chapter demonstrated the powerful structural elements inherent in the local economic mode of production which greatly reduce or in many cases nullify the effectiveness of advocating family planning

ideals. These structural elements are a significant factor in the reasons why some local women experience unwanted pregnancy and undertake unsafe abortions.

Also of importance in chapter six is the idea that unsafe abortion is a form of social struggle against the current relations of production in the village area. With the assistance of theoretical perspectives from French anthropologists, in particular Terray (1974), I explained why women resist the current patterns of exploitation within the mode of production by inducing abortion, rather than unifying in a class struggle in a typically revolutionary Marxist sense. The reason for this is the strong notion of mutual dependency which exists in the division of labour within the household units of Abladzo (Terray 1974, p.96). I explained the ritual enacted by women against a man who crossed the boundaries of culturally defined lines of disrespect towards women. I argued that this ritual was acceptable within the patriarchal culture because it had no real impact upon patterns of social relations as a whole. The ritual does not impact on the economic base of society; on its male dominated infrastructure. I stated that if women tried to unite as a class and propose the reorganisation of society on the basis of their reproductive health interests, it may be very threatening to the patriarchal social order because of the potential impact on the economic base of society and in particular, the reduction of male forms of wealth and security. The chapter argued that despite its limits, the most significant transformation in the women's circumstances has come from the 'outside intervention' of Ghana KINDNESS NGO.

In chapter seven, I continued the Marxist analysis of the Ewe community and showed the way in which cultural ideology also contributes to the maintenance of patterns of social relations which can deny women reproductive self-determination. While chapter six was concerned largely with the infrastructure of the village, chapter seven was an analysis of the superstructure or systems of institutions and ideas. This chapter provided vital insight into the patriarchal belief structure of the local Ewe. I wanted to show the influence of traditional gender ideals and the way in which these are in the interests of male control of society. The superstructure of the community sanctions the existing social order as law and establishes limits via notions of traditional values. I analysed two myths which provided examples of the philosophical and socio-religious patterns of gender ideology which inform and, in turn, contribute to patterns

of social relations in Abladzo. The key themes which emerged from the myths were male superiority and female subordination and obedience. The myths expressed the idea that by adhering to these roles the survival of individual men and women would be assured but only in this mutual co-operation or dependency, as described in the previous chapter. The chapter was intended to show that female obedience to male will was expected in the village, as is childbearing, and that women who perform a self-induced abortion do so against enormous social pressure. Moreover, even though many women are said to induce abortion, and this can be seen as a courageous form of social struggle, the patriarchal ideological components of this pro-natalist Ewe society certainly contribute to women at least doubting their capacity to transform their reproductive circumstances in other ways.

In chapter eight the analysis moved from an examination of the economic mode of production as a reason for women to experience unwanted pregnancy and subsequently perform an unsafe abortion to an analysis of Ewe sexual social relations within the institution of marriage. In accordance with Turner's (1984) theory, I argued that sexuality is not something simply natural, but very much a cultural arrangement. In the village of Abladzo, marital relations are defined by Ewe Customary Law. The law states that a husband, by virtue of a customary marriage and a bridewealth payment, is entitled to sexual rights over his wife's body. Customary law also dictates that a husband is 'supposed to be fair to his wife' but ethnographic accounts in this thesis evinced coercive sexual relations. Empirical evidence from this study thus indicated that the aspect of customary law which protects women's interests is being disregarded in current social practice in favour of male sexual gratification and patriarchal control. The sexual demands placed on some women, combined with spousal veto over contraception, create unwanted pregnancies which the women subsequently terminate unsafely in order to maintain control over their bodies and their lives.

Also in chapter eight I have shown that even unmarried women are not free from the complexities of sexual social relations which may lead to unwanted pregnancies in and around the village. The transformation of the current social praxis relating to sexual social relations or what Turner (1984) calls the Mode of Desire, reveals the gradual abandonment of the tradition of bridewealth payment, but the maintenance of

patriarchal values of male possession and ownership of women's bodies. Many male villagers now believe they are entitled to sexual control over a woman's body regardless of whether a couple is in fact married or not. The ideological concepts of male control and female obedience present in the superstructure of local Ewe culture, as described in chapter seven, are applied now to sexual relations outside marriage and, according to participants in this research, result in instances of sexual coercion and rape which lead to unwanted pregnancies and subsequent incidences of self-induced abortion. Incidences of sexual coercion are also complicated by the intersection of poverty with the transformation of forms of sexual social relations. The increasingly common social practice of gift giving in return for sexual relations, fuses more traditional male beliefs of sexual entitlement in return for material support, with new forms of sexual relations outside marriage. Unfortunately, such arrangements can be disempowering for some local women who are left with unwanted pregnancies and social stigmatisation should the relationship end. Under such circumstances some of those women feel they have little choice but to perform an unsafe abortion.

In chapter nine I continued to state the importance of considering the social as well as the biological in seeking solutions to high rates of unsafe abortion in the rural villages. As demonstrated by the ethnographic accounts of the village women who participated in this study, the social constraints placed on many women by virtue of their culturally-defined gender attributes and subsequent social value, are integral components in the search for why such women do not comply with medical and technical solutions for unwanted pregnancies and turn instead to potentially fatal techniques of self-induced abortion. The customary laws and subsequent social practices and values provide the structure of Ewe society in the region. As such they are a foundation of meaning in the lives of the local Ewe women in this study, but also become a source of tension as the women seek greater autonomy over their lived experience of an individual body-self in a cultural environment which strongly asserts that possession of a woman's body is not hers alone. It is a body which simultaneously belongs to, and may be sanctioned by Mawu [God], the community elders and the spiritual ancestors. I described the sanctions women face if the community elders discover they have performed an abortion. However, I also stressed the importance of recognising the women's agency in Giddens' (1984) terms. In particular, it is important to recognise the women's capacity to 'monitor the character

of the ongoing flow of social life' and find spaces where they were not bound by cultural conformity and could act in their own best interests (Giddens 1984, p.3). It is however regrettable that sometimes action in a woman's best reproductive interests involves her internal use of a potentially-fatal toxic plant.

In chapter ten, I extended the focus of the analysis of unsafe abortion in accordance with Scheper-Hughes' & Lock's (1987) conceptual idea of a 'political body'. This is a 'body politic, an artefact of social and political control' (Scheper-Hughes & Lock 1987, p.6). Thus the analysis moved temporarily away from the immediate environment of the village in order to provide details of the national and international efforts to reduce incidences of unsafe abortion in Ghana. I wanted to measure the effect of these on the lives of the women of Abladzo to whom I spoke. I argued that Ghana, as a nation, has undergone serious fiscal crises since independence in 1957 due to global economic recessions and poor terms of trade. Its dependence on aid and subsequent endurance of economic Structural Adjustment Programmes has severely compromised the state's ability to provide adequate healthcare services, especially in rural areas. The women of Abladzo village who participated in this research, do not have adequate access to state healthcare either physically, socially or financially. The distance, disapproval of healthcare workers and the cost of seeking medical assistance for an unwanted pregnancy combine to exclude these women from state healthcare solutions relating to abortion. Yet representatives of state healthcare continue to publically blame such women for being unable to comply with health seeking behaviour and discourses about sexuality which are produced and reproduced by the state. These discourses comply with medical and technical 'solutions' and are aimed at the body politic and deemed appropriate by an arguably well-intentioned global public health elite. It is unfortunate that the solutions and discourses produced by the elite have had almost no effect on the lives of those in need of assistance in Abladzo village.

In chapter eleven I argued that the degree to which the women of Abladzo constitute simply 'bodies' in the sense of a political artefact rather than people in genuine need of an active, compassionate response, is evinced by Ghana's Reproductive Health Strategic Plan 2007-2011. The plan largely amounts to little more than a bureaucratic buffer zone created by the Ministry of Health in response to its international political

commitments. The plan, which espouses a human-rights based approach to sexuality, health and women's reproductive rights, could be seen as simply well-intentioned rhetoric in light of the fact that the same values of equality and justice for women cannot be found within Ghanaian national law concerning marital rape or within mainstream national discourses about women's gender interests. Rather, national discourses and ideological concepts about women, sexuality and rights flow largely from what has been termed in this thesis as the level of 'the social body'. These discourses integrate aspects of cultural concepts of female subordination which are present in patriarchal tribal customary laws and values and serve to undermine international commitments to gender equality.

In chapter twelve, I argued the importance of considering unequal patterns of gender relations and sexual coercion as a cause of women's reproductive ill-health. I provided ethnographic accounts of women who stated that involuntary sexual intercourse was a reason for a distressing lack of control over reproduction which frequently led to unsafe abortion. I discussed Avotri & Walters (2001) study of the health of Ghanaian women which also argued that women's health should be conceived of in social terms. The Ewe women in their study believed that their ill-health was shaped by gender and their relationships with men. I further argued that currently, some village women who suffer from gynaecological complaints are having their problems medicalized. They receive repeated pharmaceutical solutions to gynaecological complaints which I argued are likely the negative physical effects of excessive male demands on the women's sexuality and reproductive capacity. Moreover, I provided an ethnographic example of a young woman who is unable to refuse her husband's sexual demands and has become pregnant and performed an unsafe abortion three times with the *babati te* plant. The woman now suffers from a fibroid and constant bleeding. She was treated with an injection of Oxytocin at a city hospital. A month later the injection had become ineffective but nothing had been done about the woman's social circumstances. This is the medicalization of rural women's bodies.

I turned to the work of critical medical anthropologist Scheper-Hughes (1992, p.214) to argue that the social circumstances of these women should not be silenced by pharmaceutical solutions to their biological symptoms rather, now is the time to see

and act on an opportunity for social transformation. There must be acknowledgement of the seriousness of gender inequality and the need to end the socially and culturally permitted abuse of women's bodies. This is necessary for women's health. Acknowledgement and programmes of action to prevent abusive patterns of gender relations would have far reaching positive social outcomes beyond what can be achieved by family planning programmes. Unfortunately, continued emphasis on medical and technical services without consideration of the social causes of some women's ill-health is likely to result in the medicalization of their social distress and the entrenchment of the social relations of sickness.

Chapter thirteen was a chance to address my second research question more thoroughly. I had asked if Ghana KINDNESS NGO was really empowering the local women who attempt self-induced abortion. I argued that the presence of medical assistance is life-saving for these women. Moreover, I argued that the NGO is supporting the women's resistance to current patterns of social relations which are harmful to their health. However, I also asserted that such support serves only women's Practical Gender Interests (PGI) in Molyneux's (1985) terms, as it does little to change the social inequalities which create the need for such medical assistance. There exists a very real danger of these local women having their needs medicalized, as discussed in chapter twelve, both by the well-intentioned efforts of the NGO and by private and state-run hospitals and clinics. Denial of the harm done by current gender inequalities in patterns of social sexual relations is a form of structural violence, and must be addressed not as personalised 'medical problems' but as a relevant and critical societal human-rights issue. Although I very much respect the actions of the NGO, I believe that providing injections to stop these rural women bleeding is rescuing not empowering them. The provision of contraception is another pragmatic attempt by the NGO to assist the women. However, advocating the use of contraception methods within a pro-natalist patriarchal culture is of limited value to these women. The efforts of the NGO have encouraged the women and shown them the possibility of a life without continuous pregnancies, but the realisation of that goal is still beyond the social possibilities of many village women. Thus, they continue to perform unsafe abortions. I also argued in chapter thirteen, that the transformation of the women's circumstances was not the responsibility of the NGO alone or the

responsibility of the women themselves but required multiple stakeholders to make a sincere social commitment to women's well-being (Sen 1999, p.xii).

The real empowerment of women in the sense of Molyneux's (1985) Strategic Gender Interests (SGI) will come when the social issue of women's subordination is seen as unjust and in need of active remedy. In accordance with the work of Sen (1999) and Tsey (2011), I stated that the remedy is greater equality and it needs to be applied to the social body as a whole. The 'health problem' of high incidences of unsafe abortion in rural Ghana is at least as much a social problem as a biological one. It is not right for the village social body as a whole to hide behind justifications of the harmful sexual subordination of women as being part of 'tradition' (Tsey 2011, p.79). The local Ewe tradition also includes the need to be fair, to love and to show patience, kindness and compassion. It is time for a re-examination of the local tradition. It is vital that its higher ideals and values be brought forth in social practice, and in particular, in patterns of sexual social relations. Moreover, it is not right for the global development community to pretend that medical and technical service provision is an adequate substitute for greater gender equality. The price of the compromised policy trajectory of the MDGs is quite literally paid for in blood. Just as the interpretation of tradition needs to be re-evaluated at the level of the social body, conservatism must also be re-evaluated at the level of the global body politic. The women in this study deserve nothing less. Cultures are dynamic expressions of human potential. It is vital that women from Abladzo are freed from the dangerous necessity of performing self-induced abortions that they may express both personal agency and the vast potential of Ewe culture secure in the knowledge and experience of their right to well-being.

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Appendices

1.

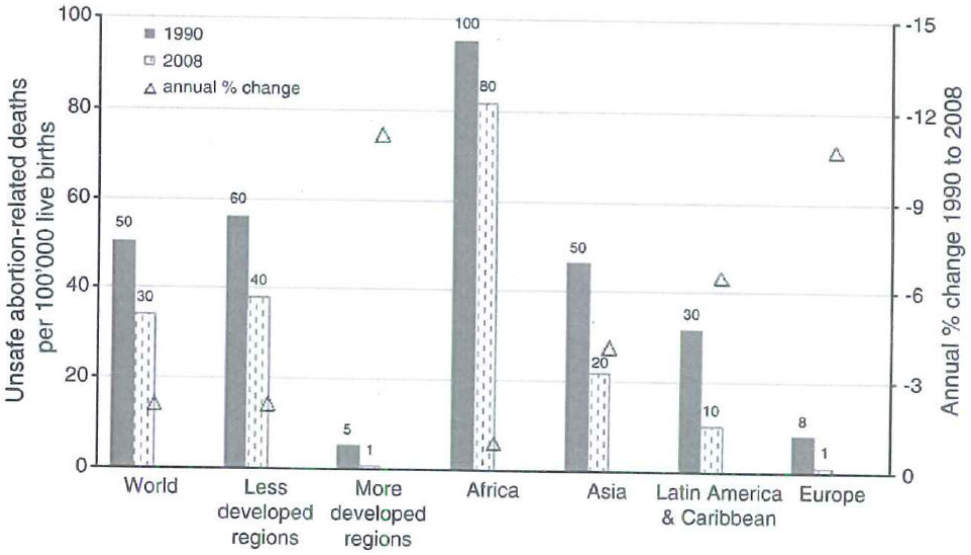

Fig. 1. Number of unsafe-abortion-related maternal deaths per 100,000 live births and annual percent change from 1990 to 2008 (Ahman, E & Shah, Iqbal (2011) 'New Estimates and Trends Regarding Unsafe Abortion Mortality'. In: *International Journal of Gynecology and Obstetrics*, Vol. 115 p.124).

2.

Table 3
Unsafe-abortion mortality ratio (number of unsafe-abortion-related maternal deaths per 100 000 live births) [a].

	1990	1997	2000	2003	2008
Worldwide	50	40	40	40	30
Developed countries	5	2	2	1	1
Developing countries	60	50	50	50	40
Africa	100	90	90	100	80
Eastern Africa	110	110	110	120	100
Middle Africa	80	80	90	100	80
Western Africa	140	110	100	110	80
Southern Africa	30	60	40	40	40
Northern Africa	20	20	20	40	30
Asia [b]	50	40	40	30	20
South/Central Asia	80	60	60	50	30
Southeastern Asia	50	40	40	30	20
Western Asia	10	10	10	10	10
Europe	8	4	4	1	1
Eastern Europe	20	10	10	2	3
Northern Europe	1	1	0	0	0
Southern Europe	2	1	1	1	0
Latin America and the Caribbean	30	20	20	10	10
Caribbean	60	50	30	20	20
Central America	20	20	10	10	8
South America	40	20	20	10	10

[a] The classification of geographical regions and subregions follows the system used by the UN Population Division [25]; regions where the incidence of unsafe abortions is negligible have been omitted from this table; the data have been rounded.

See Ahman, E & Shah, Iqbal (2011) 'New Estimates and Trends Regarding Unsafe Abortion Mortality'. In: *International Journal of Gynecology and Obstetrics*, Vol. 115 p.124).

Appendix 1: **Table of African Abortion Laws**[1]

3.

Region and Country	Grounds on which abortion is permitted (1)						
	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impair-ment	Economic or social reasons	On request[2]
Eastern Africa							
Burundi	X	X	X(2)				
Comoros	X	X	X(2)				
Djibouti	X	X(3)					
Eritrea	X	X	X(2)				
Ethiopia	X	X	X	X	X	X	
Kenya	X(4)						
Madagascar	X(4)						
Malawi	X(4)						
Mauritius	X(4)						
Mozambique	X(5)	X	X(2)				
Rwanda	X	X	X(2)				
Seychelles	X	X	X	X	X		
Somalia	X(4)						
Uganda	X(4)						
Tanzania	X(4)						
Zambia	X	X	X	X(10)	X	X	
Zimbabwe	X	X		X	X		
Middle Africa							
Angola	X(4)						
Cameroon	X	X	X(2)	X			
Central African Republic	X(4)						
Chad	X(4)	X	X (2)				
Congo	X(4)						
Equatorial Guinea	X	X	X(2)				
Gabon	X(4)						
Sao Tome e Principé	X(4)						
Zaire	X(4)						
Northern Africa							
Algeria	X	X	X				
Egypt	X(6)						
Libya	X(4)						
Morocco	X	X	X(2)				
Sudan	X			X			
Tunisia	X	X	X	X	X	X	X
Southern Africa							
Botswana	X	X	X	X	X		
Lesotho	X(7)						
Namibia	X	X	X	X	X		
South Africa	X	X	X	X	X	X	X
Swaziland	X(7)						
Western Africa							
Benin	X(4)	X	X (2)				
Burkina Faso	X	X	X(2)	X	X		
Cape Verde	X	X	X	X	X	X	X
Cote d'Ivoire	X(4)						
Gambia	X(4)	X	X				
Ghana	X	X	X	X	X		
Guinea	X	X	X(2)				
Guinea-Bissau	X(4)						
Liberia	X	X	X	X	X		
Mali	X(4)						
Mauritania	X(4)						
Niger	X(4)						
Nigeria	X(8)						
Senegal	X(4)						
Sierra Leone	X(4)	X	X				
Togo	X	X(9)					

4. **Interview Questions**

1. Can you tell me about a time the local clinic was important for you or someone you know?
2. In your opinion how has the clinic been most useful for women?
3. What are the most serious healthcare issues or problems for women in this area?
4. What did women do about health problems before the clinic was established?
5. Does the availability of medicine stop women taking risks with their health?
6. Does access to clinic medicine and contraceptives change how you see your life possibilities?
7. What reasons might a woman have for trying to abort a pregnancy in this community?
8. Why don't the local women go to the hospital?
9. Do you think the availability of clinic medicine gives women more power than before?
10. What changes do women need in this community so that they can be healthier?
11. Can you tell me exactly how a woman might do a self-induced abortion?
12. Why did you think this was the best thing for you to do?
13. Did you think it could hurt you?
14. Did your husband support this action?
15. Is self-induced abortion common in the communities around this area?
16. Have you experienced any sexual health education and if so, was it useful?
17. Did you follow the advice of the health educators and why or why not?
18. Do women have the right to say 'no' to giving birth to more babies in this community? Why or why not?
19. Is sex education changing attitudes to sex and pregnancy in these communities? Why or why not?
20. How did you feel after you received assistance from the clinic when you attempted abortion?
21. Is there anything else you would like to add about self-induced abortion or men and women or women's health in this area?

5. Picture of gari flour bagged

6. The *Babati Te* Plant known in Latin as Jathropha or Jahropa Curas.

7. The stem of the Babati Te is the instrumental part of local women's self-induced abortion technique.

8. The viscous substance contained in the stem of the plant is the poison which induces abortion.

9. An example of head loading